Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

October Term, 1993

AUTO CLUB INSURANCE ASSOCIATION,
Petitioner,
v.
PENTWATER WIRE PRODUCTS, INC.,
Respondent.

AUTO CLUB INSURANCE ASSOCIATION,
Petitioner,
v.
FREDERICK & HERRUD, INC.,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE MICHIGAN SUPREME COURT

AND APPENDIX

DAVID J. LANCTOT
HANLON, BECKER, LANCTOT, McCUTCHEON, SCHOOLMASTER & TAYLOR
2000 First Federal Building
Detroit, Michigan 48226
(313) 237-5656
Co-Counsel for Petitioner

JAMES GEORGE GROSS
Counsel of Record
GROSS & NEMETH
444 Penobscot Building
Detroit, Michigan 48226
(313) 963-8200
Co-Counsel for Petitioner

Interstate Brief & Record Company, *a division of* North American Graphics, Inc.
1629 West Lafayette Boulevard, Detroit, MI 48216 (313) 962-6230

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QUESTION PRESENTED

Respondents are self-insured ERISA welfare benefit plans which contain specific provisions stating that any applicable policy of no-fault automobile insurance provides primary coverage. Petitioner is a no-fault insurer which issued policies to certain of Respondents' participants and beneficiaries who opted to purchase coordinated medical coverage at a reduced premium. The no-fault policies accordingly state that Respondents' plans provide primary coverage. The question is:

> WHETHER FEDERAL COMMON LAW, WHICH GOVERNS THIS DISPUTE, PROVIDES FOR PRO-RATA APPORTIONMENT OF LIABILITY BETWEEN AN ERISA PLAN AND AN APPLICABLE NO-FAULT AUTOMOBILE INSURANCE POLICY WHERE BOTH THE PLAN AND THE INSURANCE POLICY STATE THAT THE OTHER IS PRIMARILY LIABLE FOR BENEFITS?

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AUTO CLUB INSURANCE ASSOCIATION,
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v.
FREDERICK & HERRUD, INC.,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE MICHIGAN SUPREME COURT

Auto Club Insurance Association respectfully petitions for a writ of certiorari to review the judgment of the Michigan Supreme Court in this case.

OPINIONS BELOW

The opinion of the Michigan Supreme Court (A-1–A-31) in these consolidated cases is reported at 443 Mich 358; 505 N.W.2d 820.

The opinion of the Michigan Court of Appeals in *Auto Club Insurance Association* v. *Frederick & Herrud, Inc.* (A-33–A-35) is reported at 191 Mich. App. 471; 479 N.W.2d 18. Earlier decisions of the Michigan Court of Appeals in that case (A-40–A-45; A-50–A-62) are reported at 175 Mich. App. 412; 438 N.W.2d 320 and 145 Mich. App. 722; 377 N.W.2d 902. The Oakland County (Michigan) Circuit Court issued no opinions.

The opinion of the Michigan Court of Appeals in *Auto Club Insurance Association* v. *Pentwater* (A-65–A-66) is unreported, as are the opinions of the Oceana County (Michigan) Circuit Court (A-70–A-80; A-81–A-82) and of the United States District Court for the Eastern District of Michigan (A-84–A-88).

JURISDICTION

The decision of the Michigan Supreme Court became final on October 21, 1993, upon entry of the orders denying Petitioner's motions for rehearing (A-95; A-97). See *Department of Banking* v. *Pink*, 317 U.S. 264, 268 (1942). The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

STATUTORY PROVISION INVOLVED

This case involves the federal common law supplementing the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. § 1001 *et seq. See, e.g., Pilot Life Insurance Co* v. *Dedeaux*, 481 U.S. 41, 56 (1987); *Franchise Tax Board* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.6 (1983).

STATEMENT OF THE CASE

Petitioner is a Michigan insurer which issued policies of no-fault automobile insurance to persons who were participants or beneficiaries[1] of Respondents, ERISA wel-

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[1] **In the trial court, Respondent Pentwater argued that the injured claimant was not a beneficiary of the plan because she was legally separated from her husband at the time of the injury. The**

(*concluded on page 3*)

fare benefit plans. In consideration of reduced premiums, those persons' no-fault insurance policies provided for coordinated medical coverage, thereby making any other health and accident plan primarily responsible for the payment of medical expenses. (A-2 n. 3, A-5 n. 8). However, the language in Respondents' plans expressly made any applicable no-fault insurance primarily responsible for payment of those expenses. (A-3 n. 4, A-5 n. 9).

The aforementioned participants and beneficiaries were injured in automobile accidents and incurred medical expenses. When Respondents failed to pay the medical bills, Petitioner paid them. As the subrogee of its insureds, Petitioner then sued Respondents for reimbursement. (A-2, A-5). The manner in which the federal question here presented was raised in the lower courts can be understood only in the context of the extensive procedural history of these cases.

A. The *Frederick & Herrud* Case

In August 1982, Petitioner filed a Complaint against Respondent Frederick & Herrud in the Oakland County (Michigan) Circuit Court. In response to Frederick & Herrud's motion for summary disposition, the circuit court concluded that liability for the expenses at issue should be prorated. Accordingly, in July 1984 that court entered an order directing Frederick & Herrud to

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(*continued from page 2*)

state trial court rejected that defense. (A-81-A-82). Respondent Pentwater pursued that issue to the Michigan Court of Appeals, but that court did not reach the issue. Although Pentwater alluded to that defense in its Brief on Appeal to the Michigan Supreme Court, it did not advance it as a basis for decision, but merely as one of several reasons for that court not to reach the federal common law question presented. The Michigan Supreme Court did not address the beneficiary issue. (A-1-A-3).

reimburse Petitioner 50% of the benefits the latter had paid.

In June 1985, the Michigan Court of Appeals reversed, holding that the legislative intent underlying § 3109a of the Michigan No-Fault Act, M.C.L. 500.3109a; M.S.A. 24.13109(1), which requires no-fault insurers to offer coordinated coverage at reduced premiums, could be served only by imposing total primary coverage on the ERISA plan. *Frederick & Herrud (I)* (A-59–A-60).

After the case was remanded to the circuit court, Frederick & Herrud moved for leave to amend its pleadings to raise the defense that any state law claims were preempted by the ERISA pursuant to 29 U.S.C. § 1144. (A-3). The circuit court denied the motion as untimely, and in November 1986 entered a judgment in favor of Petitioner in the amount of $27,911.33. (A-46).

During the pendency of Frederick & Herrud's appeal from that judgment, the Michigan Supreme Court rendered its decision in *Federal Kemper Insurance Co.* v. *Health Insurance Administration, Inc.*, 424 Mich. 537; 383 N.W.2d 590 (1986). Therein, the court cited and essentially adopted the Michigan Court of Appeals' holding in *Frederick & Herrud (I)*: the legislative intent underlying § 3109a of the Michigan No-Fault Act required holding the ERISA plan primarily liable despite the existence of language in the plan and the policy which might otherwise have required proration of liability.

In 1989, the Michigan Court of Appeals affirmed the circuit court's money judgment, citing *Federal Kemper* and the Sixth Circuit's decision in *Northern Group Services, Inc.* v. *Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. den.*, 486 U.S. 1017 (1988). *Frederick & Herrud (II)* (A-40–A-45). The *Northern Group Services* case held that the preemption provision of the ERISA

did not affect the operation of § 3109a of the Michigan No-Fault Act as interpreted by *Federal Kemper*.

Following the Michigan Supreme Court's denial of its application for leave to appeal, Frederick & Herrud petitioned this Court for a writ of certiorari. During the pendency of that petition, this Court rendered its decision in *FMC Corp.* v. *Holliday*, 498 U.S. 52 (1990). That decision effectively overruled *Northern Group Services*.

On December 3, 1990, this Court vacated the judgment of the Michigan Court of Appeals in *Frederick & Herrud (II)* and remanded the case for further consideration in light of *FMC Corp.* v. *Holliday*, *supra*. (A-36–A-38). On remand, the Michigan Court of Appeals reversed the circuit court's judgment in favor of Petitioner. *Frederick & Herrud (III)* (A-33–A-35).

Petitioner filed a motion for rehearing, arguing that federal preemption did not require that its claim be dismissed, but rather that the conflict between the parties' coordination of benefit (COB) clauses be resolved according to federal common law. (A-12). The Michigan Court of Appeals denied rehearing. (A-96). The Michigan Supreme Court granted Petitioner's application for leave to appeal and ordered that the case be argued and submitted together with the *Pentwater* case. (A-32).

B. The *Pentwater* Case

In June 1986, Petitioner filed its Complaint against Respondent Pentwater in the Oceana County (Michigan) Circuit Court. A month later, Pentwater sought to remove the case to the United States District Court for the Western District of Michigan, invoking federal question jurisdiction on the ground that the ERISA preempted Petitioner's claim against it. Shortly thereafter, the parties stipulated to hold the matter in abeyance

pending the Sixth Circuit's decision in *Northern Group Services, supra*. (A-91–A-93).

Following the issuance of *Northern Group Services*, the federal district court remanded the instant case to the state court on the ground that in the absence of preemption, Petitioner's claim was a state law cause of action only. (A-83–A-88).

On remand, the circuit court granted summary disposition in favor of Petitioner. (A-81–A-82). On April 9, 1990, that court entered judgment in favor of Petitioner in the amount of $511,253.08. (A-69). Pentwater filed a post-judgment motion, arguing that § 3109a of the Michigan No-Fault Act was preempted by the ERISA. (A-6 n.11). The motion was denied. (A-68).

During the pendency of Pentwater's appeal to the Michigan Court of Appeals, this Court rendered its decision in *FMC Corp.* v. *Holliday, supra*. On January 6, 1992, the Michigan Court of Appeals, citing its decision on remand from this Court in *Frederick & Herrud (III)*, reversed the circuit court and remanded for entry of judgment in favor of Pentwater. (A-65–A-66). The Court of Appeals denied Petitioner's motion for rehearing. (A-97).

Petitioner filed an application for leave to appeal to the Michigan Supreme Court. In that pleading Petitioner argued, as it did in *Frederick & Herrud (III)*, that even if the ERISA preempts the application of state law to the dispute, federal common law would govern the resolution of the conflict between the parties' respective COB clauses, and liability would be prorated.

On November 2, 1992, the Michigan Supreme Court granted the application for leave to appeal and ordered that the case be argued and submitted together with the *Frederick & Herrud* case. (A-64).

C. The Decision of the Michigan Supreme Court

After holding that as a matter of federal law Petitioner's subrogee status gave it standing to pursue its claim against Respondents (A-10–A-12), the Michigan Supreme Court addressed Respondents' argument that the federal issues were not preserved for appeal because they were not raised in the circuit courts. Noting that in both cases the ERISA preemption issue was reconsidered as a direct result of this Court's mandate in *Frederick & Herrud (II)*, the court held that the issues were preserved for review for three reasons:

(1) Petitioner had obtained judgments in its favor in both cases, and therefore was not required to preserve the federal common law issue.

(2) The federal courts have demonstrated a preference for considering ERISA issues despite a party's failure to frame them at the commencement of the litigation.

(3) Any delay in the treatment of the ERISA issues was attributable to their recent development in the federal courts, and not to any dilatory practice by the parties.

(A-12–A-13). The court also noted that under Michigan practice, it had the discretion to consider the issue because it was necessary to a proper determination of the case. (A-13 n. 24).

As to the merits of the issue, the court recognized that in *Auto Club Insurance Ass'n* v. *Health & Welfare Plans, Inc.*, 961 F.2d 588 (6th Cir. 1992), and *Lincoln Mutual Casualty Co.* v. *Lectron Products, Inc., Employee Health Benefit Plan*, 970 F.2d 206 (6th Cir. 1992), the Sixth Circuit had held that the ERISA preemption does not resolve disputes such as this, but simply renders

federal (rather than state) common law controlling as to the outcome. (A-8–A-9, A-27). The court also noted that two decisions from the United States District Court in Michigan had reached different conclusions as to the federal common law rule applicable to this dispute. *Lincoln Mutual Casualty Co.* v. *Lectron Products, Inc., Employee Health Benefit Plan (On Remand)*, 823 F. Supp. 1385 (E.D. Mich. 1993) (enforcing ERISA plan COB clause and ignoring insurance policy COB clause); *Auto Owners Insurance Co.* v. *Thorn Apple Valley*, 818 F. Supp. 1078 (W.D. Mich. 1993) (prorating liability between ERISA plan and insurance policy). (A-9–A-10). The court further noted the Sixth Circuit's apparent approval of the pro rata approach adopted by the Seventh Circuit in *Winstead* v. *Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. den.* 488 U.S. 1030 (1989). (A-10).

Nevertheless, the Michigan Supreme Court opted to follow *Lincoln Mutual (On Remand)* on the ground that § 3109a "does not reach an ERISA plan with a COB clause where that clause is unambiguous", and that such a clause "must be given its clear meaning without the creation of any artificial conflict based upon [§ 3109a]". (A-27–A-28).

On October 21, 1993, the court denied Petitioner's motions for rehearing. (A-95, A-97).

REASONS FOR GRANTING THE PETITION

There is a general recognition of the need for a uniform federal common law rule governing conflicting COB clauses in ERISA cases. However, there the consensus ends. The cases which have purportedly applied "the" federal common law rule are literally all over the judicial map. The continuing litigation generated by that confusion is starkly inconsistent with the Congressional

design of an ERISA system governed by a uniform and easily applied body of federal law. It is time for this Court to end a decade of litigation over a readily resolvable question.

I.

THE FEDERAL COMMON LAW RULE ARTICULATED BY THE MICHIGAN SUPREME COURT DIRECTLY CONFLICTS WITH A DECISION OF THE SEVENTH CIRCUIT, INDIRECTLY CONFLICTS WITH PRONOUNCEMENTS BY THE THIRD AND SIXTH CIRCUITS, AND IS INCONSISTENT WITH THE DECISIONS OF SEVERAL OTHER STATE AND FEDERAL COURTS.

With regard to the question here presented, the California Court of Appeal recently observed that "federal law is not uniform, and is not going to be uniform until the United States Supreme Court finally decides the matter." *Inter Valley Health Plan* v. *Blue Cross/Blue Shield of Connecticut*, 16 Cal. App. 4th 60, 66; 19 Cal. Rptr. 2d 782 (1993), *pet. for cert. filed*, 62 U.S.L.W. 3378 (11/19/93). The Michigan Supreme Court's decision in the instant case provides another woeful illustration of that state of affairs.

The federal common law rule promulgated by the Michigan Supreme Court in the instant case is that where an ERISA plan and a non-ERISA plan or policy both contain unambiguous and irreconcilable COB clauses purporting to make the other primary, the language in the non-ERISA policy is to be ignored. In reaching that holding, the Michigan Supreme Court considered and rejected the rule applied by the Seventh Circuit in *Winstead* v. *Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. den.*, 488 U.S. 1030 (1989).

In *Winstead*, the Seventh Circuit affirmed the district court's decision to prorate liability between an ERISA plan and a no-fault insurer where both the plan and the

policy contained unambiguous and irreconcilable COB clauses purporting to make each excess over the other.

Although stopping short of requiring application of the *Winstead* rule, in two recent cases the Sixth Circuit cited it with approval in the course of remanding to the district court for further proceedings. *Lincoln Mutual Casualty Co.* v. *Lectron Products, Inc., Employee Health Benefit Plan, supra*; *Auto Club Insurance Ass'n* v. *Health & Welfare Plans, Inc., supra*.[2]

Although not applying it in the cases before them, other courts have also cited proration or some other form of apportionment between coverages as the correct resolution of conflicting COB clauses in the ERISA context. *Blue Cross and Blue Shield of Kansas, Inc.* v. *Riverside Hospital*, 237 Kan. 829, 835, 703 P.2d 1384 (1985); *Blue Cross & Blue Shield of Mississippi, Inc.* v. *Larson*, 485 So2d 1071, 1075 (Miss. 1986); *Starks* v. *Hospital Service Plan of N.J., Inc.*, 182 N.J. Super. 342, 440 A.2d 1353, 25 A.L.R. 4th 1009, 1017-18 (1981), *aff'd*, 91 N.J. 433, 453 A.2d 159 (1982). *See also, Northeast Department ILGWU Health and Welfare Fund* v. *Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 161 n.13 (3rd Cir. 1985). The decision in the instant case indirectly conflicts with those cases to the extent that it rejected the apportionment approach.

The decision of the Michigan Supreme Court is also inconsistent with other cases which have adopted a

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2 As noted above, subsequent to the Sixth Circuit's decisions in *Health & Welfare Plans* and *Lectron Products*, two federal district court judges in Michigan rendered inconsistent decisions on the question presented here. Both cases are currently pending on appeal to the Sixth Circuit. *Lincoln Mutual Casualty Co.* v. *Lectron Products, Inc., Employee Health Benefit Plan (On Remand)*, 823 F. Supp. 1385 (ED Mich. 1993) (Sixth Circuit No. 93-1894); *Auto-Owners Insurance Co.* v. *Thorn Apple Valley*, 818 F. Supp. 1078 (WD Mich. 1993) (Sixth Circuit No. 93-1606).

potpourri of other approaches to conflicting COB clauses in the ERISA context. *P.M. Group Life Insurance Co.* v. *Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir. 1992) ("birthday rule"); *Reenforcing Iron Workers Local 426 Health and Welfare Fund* v. *Michigan Bell Telephone Co.*, 746 F. Supp. 668 (E.D. Mich. 1990) (same); *Inter Valley Health Plan* v. *Blue Cross/Blue Shield of Connecticut, supra* (follow terms of state court divorce judgment); *Blue Cross and Blue Shield of Kansas, Inc.* v. *Riverside Hospital, supra* (ERISA plan primary under non-ERISA policy because claimant was participant in former and covered dependent under latter).

Given the above-described judicial landscape, the Michigan Supreme Court could hardly have rendered a decision in the instant case which did not directly or indirectly conflict with a decision of a federal Circuit Court or of another state court of last resort. That circumstance underscores the need for this Court to decide the question presented and resolve those numerous conflicts.

II.

THE FEDERAL COMMON LAW RULE ARTICULATED BY THE MICHIGAN SUPREME COURT IS LEGALLY UNSOUND AND INCAPABLE OF UNIFORM APPLICATION.

The federal common law "rule" promulgated by the Michigan Supreme Court is that Respondents' COB clauses must be enforced because the ERISA preempts § 3109a of the Michigan No-Fault Act. (A-27–A-28). That holding is erroneous for two distinct but related reasons.

First, the Michigan Supreme Court misapprehended the nature of the conflict presented to it. The question was not whether § 3109a should be permitted to create

an "artificial conflict" (A-28) between the parties' contracts. The inapplicability of state law, which necessarily includes state statutes, was given. Thus, the conflict was not, and could not be, between § 3109a and the ERISA. Rather, the conflict was between the irreconcilable COB clauses in the parties' contracts. The result of the court's failure to appreciate the nature of the conflict presented was an almost perfect circularity of reasoning.

Second, the court's circular reasoning led it to a holding in direct conflict with the line of cases holding that the mere fact of ERISA preemption does *not* mandate a result in favor of the ERISA plan as a matter of federal common law. *Lincoln Mutual Casualty Co.* v. *Lectron Products, Inc., Employee Health Benefit Plan, supra* at 210-11; *ACIA* v. *Health and Welfare Plans, Inc., supra* at 592-93; *Winstead* v. *Indiana Insurance Co., supra* at 433-34; *Blue Cross and Blue Shield of Kansas, Inc.* v. *Riverside Hospital, supra* at 832-33, 836.

Moreover, the rule articulated by the Michigan Supreme Court is incapable of uniform application in cases governed by the ERISA. By hypothesis, the rule cannot apply to disputes between conflicting COB clauses in two ERISA plans. See *P.M. Group Life Insurance Co.* v. *Western Growers Assurance Trust, supra*; *Northeast Department ILGWU Health and Welfare Fund* v. *Teamsters Local Union No. 229 Welfare Fund, supra*; *Inter Valley Health Plan* v. *Blue Cross/Blue Shield of Connecticut, supra*. Nor would its rationale apply to COB conflicts between an ERISA plan and a non-ERISA contract in the absence of any state law requiring the latter to include coordinated coverage.

In short, the mischief wrought by the Michigan Supreme Court is not limited to adding yet another "rule" to the patchwork which already exists. The lack

of any defensible legal rationale for that facile but fallacious "rule" portends more irrational decisions by courts inclined to follow it.

III.

IT IS IMPORTANT THAT THIS COURT PROMULGATE A UNIFORM FEDERAL COMMON LAW RULE GOVERNING CONFLICTING COORDINATION OF BENEFIT CLAUSES IN CASES GOVERNED BY THE ERISA.

The importance of the question presented is a function of the number of persons affected by the ERISA, the number of extant and potential disputes involving that question, and the needlessly wasteful ramifications of allowing the issue to remain unresolved.

The national implications of disputes such as this in terms of the number of persons and entities affected was aptly stated to this Court by Respondent Frederick & Herrud in its previous visit to this Court:

> "1 The importance of the issues presented in this case is underscored by the fact that approximately 95% of American workers are participants in employer-sponsored health plans. Wiatrowski, *Comparing employee benefits in the public and private sectors*, reprinted in *U.S. Bureau of Labor Statistics, Department of Labor, Monthly Labor Review*, p. 4 (December 1988). The prevalence of no-fault automobile insurance laws across the country also ensures that the issues presented here will have more than mere local implications."

(Petition for Writ of Certiorari of Frederick & Herrud, Inc., No. 89-1125, p. 5 n.1).

Moreover, unlike the relatively limited scope of the questions presented in No. 89-1125, the question here presented is not necessarily limited to disputes

between ERISA plans and no-fault insurers. Disputes over conflicting COB clauses also arise between one ERISA plan and another. *See, e.g., P.M. Group Life Insurance Co.* v. *Western Growers Assurance Trust, supra*; *Northeast Department ILGWU Health and Welfare Fund* v. *Teamsters Local Union No. 229 Welfare Fund, supra*; *Inter Valley Health Plan* v. *Blue Cross/Blue Shield of Connecticut, supra*. A *uniform* federal common law rule would resolve *all* such disputes.

Finally, it is painfully obvious that the federal and state courts deciding such disputes have had no success in developing a uniform federal common law rule. Although the apportionment rule herein suggested has wide and increasing currency in state common law, the instant case is only the most recent example of the pervasive insistence of both federal and state courts on applying or inventing others in ERISA cases. Given the dim prospects for any kind of consensus, it is certain that litigation on the question presented will continue to consume resources which could be better spent on health care for the workers whom Congress intended to benefit.

CONCLUSION

This Court should grant the Petition for Writ of Certiorari.

In the alternative, in light of the pendency of the question here presented before the United States Court of Appeals for the Sixth Circuit, this Court should hold the petition in abeyance pending the decisions of the Sixth Circuit, at which time it should either grant this petition or vacate the decision of the Michigan Supreme Court and remand these cases with appropriate instructions.

Respectfully submitted,

By: /s/ JAMES G. GROSS
Counsel of Record
GROSS & NEMETH
444 Penobscot Building
Detroit, Michigan 48226
(313) 963-8200
Co-Counsel for Petitioner

By: DAVID J. LANCTOT
HANLON, BECKER, LANCTOT,
McCUTCHEON, SCHOOLMASTER & TAYLOR
2000 First Federal Building
Detroit, Michigan 48226
(313) 237-5656
Co-Counsel for Petitioner

DATED: January 17, 1994

APPENDIX TO PETITION FOR CERTIORARI

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OPINION
–443 MICH 358–

(State of Michigan — Michigan Supreme Court)

(Argued March 3, 1993 (Calendar Nos. 7-8);
Decided August 31, 1993)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff-Appellant, v FREDERICK & HERRUD, INC., Defendant-Appellee — No. 93819; AUTO CLUB INSURANCE ASSOCIATION, Plaintiff-Appellant, v PENTWATER WIRE PRODUCTS, INC., Defendant-Appellee — No. 93925)

BEFORE THE ENTIRE BENCH

RILEY, J.

In this case, we are called upon to decide the primacy of insurance liability between plaintiff no-fault insurer and two different employee health benefit plans established by defendants pursuant to the Employee Retirement Insurance Security Act,[1] in which each contract with their insured contains unambiguous coordination-of-benefits (COB) clauses. Related questions are whether the ERISA permits subrogation of claims, whether the issue was properly preserved for this Court's review, and whether the existence of "stop-loss" insurance has any bearing on our determination of the first issue.

We hold that subrogation of claims is permitted under the ERISA. We also conclude that the ERISA issues were preserved for this Court's review. In addition, we

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1 **29 USC 1001** *et seq.*

find that the COB clause in an ERISA plan must be given its plain meaning despite the existence of a similar clause in a no-fault insurance policy as a matter of federal common law. Finally, we conclude that the existence of stop-loss insurance is irrelevant to the issue of preemption under the facts of these cases. Thus, we affirm the opinions of the Court of Appeals.

I
FACTS AND PROCEDURAL HISTORY

A.
AUTO CLUB v *FREDERICK & HERRUD, INC*

Plaintiff Auto Club paid no-fault automobile accident benefits to seven of its insureds who worked for defendant Frederick & Herrud or who were dependents of Frederick & Herrud employees.[2] Pursuant to a COB clause[3] in its contract with the insureds and a related subrogation clause, plaintiff filed a complaint to recover its expenditures from defendant under the terms of defendant's self-funded employee welfare benefits plan

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2 At some time after proceedings were filed in this matter, the name of the company was changed to Thorn Apple Valley, Inc. The caption was changed to reflect the proper name of defendant by the United States Supreme Court in 498 US 996; 111 S Ct 552; 112 L Ed 2d 559 (1990). For purposes of consistency, defendant will be referred to as "Frederick & Herrud" or "defendant" except where its present name appears in an official citation.

3 Auto Club's insurance policy provides in pertinent part:

> In consideration of the reduced premium for Personal Protection Insurance and a presumption that medical benefits are provided by another source, . . . under the Medical Benefits Coverage, sums paid or payable to or on behalf of the named insured . . . shall be reduced by any amount paid or payable under any . . . disability or hospitalization insurance, medical, surgical or hospital direct pay or reimbursement health care plan . . . .

The option of a lowered insurance premium for a policy providing for coordinated benefits is a mandatory feature of all no-fault automobile insurance policies issued in Michigan. See MCL 500.3109a; MSA 24.13109(1).

(hereafter "Frederick plan") that also contains a COB clause.[4]

In response to defendant's motion for summary disposition, the circuit court concluded that neither party was entitled to a judgment that the other was solely responsible for the benefits paid. Having determined that the competing COB clauses were unambiguous, the court entered a judgment ordering both parties to pay half the benefits owed to the insureds.

The Court of Appeals reversed the circuit court's summary judgment order concluding that the legislative intent behind MCL 500.3109a; MSA 24.13109(1) required that a no-fault insurer provide only secondary coverage in cases involving competing COB clauses. 145 Mich App 722, 728; 377 NW2d 902 (1985). The case was remanded to the circuit court for entry of an appropriate order.

Following remand, defendant retained the services of different counsel. Defendant moved for leave to file an amended answer and notice of affirmative defenses that, for the first time, asserted preemption of any state law claims by the ERISA. The circuit court denied the motion to amend. Several months later, it entered an order denying defendant's motion for summary disposition for lack of subject matter jurisdiction and granted plaintiff's motion for entry of judgment.

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4 **Section twenty-one of defendant's plan provides:**

> **In addition to the benefits payable under this plan, sometimes an employee or defendant is entitled to benefits for the same hospital or medical expenses under the group fault or no-fault auto insurance, individual no fault auto insurance . . . . Should this type of duplication occur, the benefits under this plan will be co-ordinated so that the total benefits from all plans will not exceed the hospital or medical expenses actually incurred. In all cases employees with no-fault auto insurance coverage, the auto insurance carrier will be primary.**

Defendant appealed the denial of its motion to amend and its motion for summary disposition. The Court of Appeals affirmed the judgment on the basis of the holding of the United States Court of Appeals for the Sixth Circuit in *Northern Group Services, Inc* v *Auto-Owners Ins Co*, 833 F2d 85 (CA 6, 1987), cert den 486 US 1017 (1988), which provided that the Michigan rule for coordination of benefits in MCL 500.3109a; MSA 24.13109(1) was *not* preempted by the ERISA. 175 Mich App 412, 417-419; 438 NW2d 320 (1989). This Court denied defendant's application for leave to appeal.[5]

Defendant sought a writ of certiorari in the United States Supreme Court.[6] In lieu of plenary consideration, the United States Supreme Court vacated the judgment of the Court of Appeals and remanded for further consideration in light of its recently decided *FMC Corp* v *Holliday*, 498 US 52; 111 S Ct 403; 112 L Ed 2d 356 (1990).

On remand, the Court of Appeals noted that *Northern Group Services, supra*, was effectively overruled by *FMC Corp*. 191 Mich App 471, 474; 479 NW2d 18 (1991). Accordingly, it ruled that the state regulation found in MCL 500.3109a; MSA 24.13109(1) is preempted by the ERISA and reversed the circuit court's judgment. *Id.* That defendant's health plan may have been partially insured was held to be immaterial because plaintiff failed to preserve the issue. *Id.* This Court granted plaintiff's application for leave to appeal for consideration with the companion case.[7]

B

AUTO CLUB v *PENTWATER WIRE PRODUCTS*

Plaintiff Auto Club paid no-fault automobile accident benefits to its insured, Alice Guetzka. Pursuant to a COB

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5 **433 Mich 902 (1989).**

6 **See n 2.**

7 **441 Mich 878 (1992).**

clause[8] in the contract, together with its right of subrogation of the insured's claims, plaintiff filed a complaint against defendant, the ERISA health plan of her estranged husband's employer, seeking recoupment of $357,699 in benefits paid, together with roughly $150,000 in interest and attorney fees. The employee health benefits plan ("Pentwater plan") provided for payment of the first $14,000 of any valid claim in addition to any amounts over $1,000,000. The gap in coverage occasioned by these provisions was filled by "stop-loss" insurance.[9] The Pentwater plan also contains a COB clause.[10]

One month after the complaint was filed in a state court, defendant sought to remove the case to the United States District Court for the Western District of Michigan on the ground that the ERISA preempted plaintiff's claim. Shortly thereafter, the parties stipulated to

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8 The relevant provision states:

> If the Declaration Certificate shows Coordinated Medical Benefits, sums paid or payable to or for you or any relative shall be reduced by any amount paid or payable under any valid and collectible: individual, blanket or group disability or hospitalization insurance; medical, surgical or hospital direct pay or reimbursement health care plan; Workers' Compensation Law, disability law of a similar nature, or any other state or federal law; or car or premises insurance affording medical expense benefits.

9 "Stop-loss" coverage consists of the purchase of insurance by a benefits plan to pay valid claims according to a plan's terms. A plan may be entirely self-funded or it may shift the risk of paying benefits to an insurance company by using funds allocated to the plan for payment of insurance premiums. In the instant case, the Pentwater plan bears the risk of employee claims up to the $14,000 figure and over $1,000,000.

10 The clause provides:

> [N]o-fault Auto coverage is always considered to be the primary Plan, and This Plan shall be deemed to provide only "excess insurance."

an abeyance pending the decision of the United States Court of Appeals for the Sixth Circuit in *Northern Group Services, Inc* v *Auto Owners Ins Co, supra*. Following issuance of the decision in *Northern Group Services*, the district court remanded the case to the state court because "Auto Club [pleaded] a state law cause of action only" in the absence of preemption.

On remand, the circuit court granted plaintiff's motion for summary disposition while denying defendant's motion. An order was entered on July 25, 1989, granting plaintiff's motion for partial summary judgment. On April 9, 1990, the circuit court entered an amended judgment in favor of plaintiff for $511,253.08. Defendant's motion for a new trial or relief from the judgment was denied on January 29, 1990.[11]

Defendant filed its claim of appeal after the United States Supreme Court decided *FMC Corp*. The Court of Appeals did, however, have the benefit of the *FMC Corp* holding because it had already been considered and adopted by another panel in the companion case.[12] Therefore, relying on this earlier precedent, the Court reversed, concluding that MCL 500.3109a; MSA 24. 13109(1) was preempted by ERISA, that the existence of

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11 **The brief in support of the motion appears to be the first time that the ERISA issue was squarely presented to the circuit court. Defendant asserted the following as its basis for the motion:**

> **[I]n light of this new decision [*Northern Group Services, supra*], the defendant asserts that this court should reconsider its prior ruling on the parties' motions and, this court should find that *pursuant to the Liberty Mutual* [*Ins Group* v *Iron Workers Health Fund of Eastern Michigan*, 879 F2d 1384 (CA 6, 1989)] *decision that Section 3109a is preempted, and therefore, the Auto Club Insurance Association policy is primary and there is no cause of action against the defendant.* [Emphasis added.]**

12 **See *Auto Club Ins Ass'n* v *Frederick & Herrud, Inc (On Remand), supra*.**

"stop-loss" insurance was irrelevant to the issue of preemption, and that plaintiff failed to preserve its argument that ERISA preemption required consideration of the federal common law on the conflicting clauses issue rather than dismissal of the action. Unpublished opinion per curiam of the Court of Appeals, decided January 6, 1992 (Docket No. 126174). With the assistance of new counsel, plaintiff moved for a rehearing that was denied in an order entered April 2, 1992. This Court granted plaintiff's application for leave to appeal for consideration of the ERISA issues together with the companion case.[13]

C

Before turning to the substantive issues, a brief overview of how the issues have reached this Court is in order. It would be fair to say that the primary issue regarding the conflicting coordination-of-benefits clauses has only recently been defined by a flurry of federal cases. Originally, plaintiff filed complaints for the recoupment of its expenditures alleging state law claims surrounding the interpretation of its COB clauses and its rights under a subrogation theory. In 1985, our Court of Appeals held that a no-fault insurer was to be considered secondarily liable to any health and accident insurer where both insurers' contracts with an insured contained COB clauses. *Frederick & Herrud*, 145 Mich App 727-731.[14]

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13 441 Mich 879 (1992).

14 This Court adopted the reasoning of the Court of Appeals in *Federal Kemper Ins, Inc* v *Health Ins Administration, Inc*, 424 Mich 537; 383 NW2d 590 (1986). In *Kemper*, we noted the existence of a majority rule on the issue, which attempts to reconcile the conflict by discerning the parties' intent, and a minority rule considering the conflicting clauses "mutually repugnant" and assigns pro-rata lia-

(*concluded on page A-8*)

In 1985, the federal courts also began to focus their attention on the ERISA preemption problem in cases involving health and welfare benefits plans.[15] And, following the landmark decision in *FMC Corp*, the issues implicated here reached the Sixth Circuit in several cases. In *Auto Club Ins Ass'n* v *Health & Welfare Plans, Inc*, 961 F2d 588 (CA 6, 1992), the court determined that ERISA preemption, a point made clear in *FMC Corp*, did not ipso facto render the COB clause in a no-fault insurance policy void where it conflicted with a similar clause in an ERISA health plan. The case was remanded to the district court to determine "how a court should resolve a conflict between two (presumably) unambiguous, seemingly valid, and irreconcilable coordination of benefits clauses, one contained in an ERISA plan and one in a non-ERISA policy." *Id.* at 594.[16] In *Lincoln Mutual Casualty Co* v *Lectron Products, Inc, Employee Health Benefit Plan*, 970 F2d 206, 211 (CA 6, 1992), the Sixth Circuit concluded:

> As we noted in *Auto Club*, the fact that § 3109a is preempted by ERISA does not necessarily render Lincoln's COB clause void, nor does it

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(*continued from page A-7*)

bility. *Id.* at 542-543. Notwithstanding the existence of these views, the Court determined that the legislative intent behind MCL 500.3109a; MSA 24.13109(1) required the conclusion that the health insurer was primarily liable in this situation.

> **We conclude, therefore, that defendant health insurer is primarily liable. Giving effect to plaintiff's coordinated benefits provision furthers the purpose of § 3109a to contain both auto insurance costs and health care costs, while eliminating duplicative recovery. [*Id.* at 551.]**

15 See *Metropolitan Life Ins Co* v *Massachusetts*, 471 US 724; 105 S Ct 2380; 85 L Ed 2d 728 (1985), discussed *infra* at 28-30.

16 We are told that the parties to this case settled the controversy without opinion of the district court.

> necessarily mean that the Plan's terms prevail. We have before us, then, two valid, unambiguous, and irreconcilable clauses. Because no federal statutory law addresses the issue of how to resolve the conflict between the clauses, this case must be resolved by applying *federal common law*. [Emphasis added, citations omitted.][17]

On remand in *Lincoln Mutual*, the district court concluded that Michigan's interpretation of MCL 500.3109a; MSA 24.13109(1) would impermissibly subject ERISA health plans to variable state regulation. 823 F Supp 1385, 1394 (ED Mich, 1993). Citing several unpublished Sixth Circuit cases involving ERISA issues other than the conflict at issue here, the court held that "the straightforward language of the ERISA policy provision . . . must be given its natural meaning." *Id.* at 1392. The court further stated that, pursuant to the clear import of *FMC Corp*, the ERISA health plan was not an insurance com–

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17 In *Northern Group Services, supra*, the Sixth Circuit concluded that MCL 3109a; MSA 24.13109(1) was the type of state regulation that survived ERISA preemption. 833 F2d 95. *Northern Group Services* is, however, a pre-*FMC Corp* case and is accordingly of questionable import. In several other cases, the federal courts refrained from deciding the conflict by characterizing the clauses in ERISA plans as exclusions rather than as COB clauses. The exclusionary language in the ERISA plans was then given its plain meaning, which removed any conflict with a COB clause in a no-fault insurance policy. See, e.g., *Liberty Mutual Ins Group* v *Iron Workers Health Fund of Eastern Michigan*, n 11 *supra*; *Allstate Ins Co* v *Detroit Millmen's Health & Welfare Fund*, 729 F Supp 1142 (ED Mich, 1990); *Transamerica Ins Co of North America* v *Peerless Industries (Masco)*, 698 F Supp 1350 (WD Mich, 1988). See also *Transamerica Ins Co of America* v *IBA Health & Life Assurance Co*, 190 Mich App 190; 475 NW2d 431 (1991)("[W]here a clear and unambiguous limitation of benefits for injuries related to auto accidents appears in a health and accident insurance policy . . . such limitation is a valid exclusionary provision").

pany subject to regulation by state law. *Id.* at 1392, n 9.[18]

Two months earlier, the United States District Court for the Western District of Michigan had concluded that the federal common-law question framed by the Sixth Circuit in *Auto Club* and *Lincoln Mutual*, *supra*, required adoption of the pro-rata apportionment rule espoused in *Winstead* v *Indiana Ins Co*, 855 F2d 430 (CA 7, 1988). *Auto Owners Ins Co* v *Thorn Apple Valley*, 818 F Supp 1078 (WD Mich, 1993). Although neither of the recent Sixth Circuit cases articulated a federal common-law rule, both noted, with apparent approval, that *Winstead* decision. *Auto Club*, 961 F2d 594-595; *Lincoln Mutual*, 970 F2d 211.[19]

II

As a threshold matter, we acknowledge both defendants' arguments that plaintiff is not a proper subrogee of its insureds' right to seek payment from their ERISA plans. We disagree.

The ERISA creates a cause of action against an employee benefit plan in favor of participants and beneficiaries. 29 USC 1132(a)(1). A participant is an employee who is or may become eligible to receive a benefit from the plan. 29 USC 1002(7). A beneficiary is one who is designated by a participant or by the terms of the plan

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18 The district court's strict interpretation of the ERISA plan's terms included emphasis on the fact that the clause *excluded* coverage of more than $300 for auto accident injuries. We read the case not as an "exclusion" case, see n 16 *supra*, but as a preemption case squarely addressing the issues before us today.

19 Both of the recent federal district court cases are on appeal to the Sixth Circuit to determine what the federal common law should be in the case of conflicting COB clauses, one of which is contained in an ERISA health and welfare benefits plan.

as one entitled to a benefit under the plan. 29 USC 1002(8). The ACIA is not an employee and is therefore not a participant. Nor does either plan provide for those other than employees or their designees to receive benefits, and, therefore, it appears that the ACIA is not a beneficiary. The ACIA, however, argues that it is a subrogee of a plan participant or beneficiary, and therefore it may bring its claim for a benefit under the plan on behalf of its insureds — the plan participant and the plan beneficiary.

The federal courts that have addressed this question have not come to any consensus. Some courts hold that ERISA definitions of participant and beneficiary require a narrow, literal interpretation, and because the ERISA itself makes no provision for suits by subrogees, the subrogee has no standing to pursue a claim for benefits. See, e.g., *Allstate Ins Co* v *The 65 Security Plan*, 879 F2d 90 (CA 3, 1989); *Nationwide Mutual Ins Co* v *Teamsters Health & Welfare Fund*, 695 F Supp 181 (ED Pa, 1988). Other federal courts, including the United States District Court for the Eastern District of Michigan, have held that a subrogee does have standing to pursue a claim for benefits. *Allstate Ins Co* v *Operating Engineers*, 742 F Supp 952 (ED Mich, 1990). See also *Misic* v *Building Service Employees Health & Welfare Trust*, 789 F2d 1374 (CA 9, 1986), and *Hermann Hosp* v *MEBA Medical & Benefits Plan*, 845 F2d 1286 (CA 5, 1988)(an assignee of a participant has standing to claim benefits).

We believe that the better approach is to permit subrogation as a matter of public policy. Subrogation ensures the rapid payment of benefits to an injured person who might otherwise have to wait for resolution of any litigation over which the insurer is liable for benefits. From the federal standpoint, this comports with the federal policy of benefiting the employees. Although a

successful suit has the effect of lowering funds in the ERISA plan, only those funds that are owed to the insured may be collected. Moreover, subrogation benefits this state's citizens for the same reason. Accordingly, we favor the line of federal cases permitting subrogation. See *Operating Engineers*, *Misic*, and *Hermann Hosp*, *supra*. See also *Allstate Ins Co* v *Detroit Millmen's Health & Welfare Fund Trust*, 729 F Supp 1142, 1146 (ED Mich, 1990). We therefore conclude that a subrogee may stand in the shoes of a subrogor ERISA plan member until we are otherwise directed by federal precedent.

III

Both defendants allege that plaintiff failed to preserve the ERISA issues for appellate review by failing to timely raise them in the proceedings before the circuit courts. In *Frederick & Herrud*, defendant first raised the ERISA preemption issue after the Michigan Court of Appeals ruled in favor of plaintiff on the basis of its interpretation of the legislative intent behind MCL 500.3109a; MSA 24.13109(1). 145 Mich App 731-734.[20] The ERISA issue was decided in favor of defendant after the United States Supreme Court vacated the judgment of our Court of Appeals with directions to reconsider in light of *FMC Corp.* In *Pentwater*, the Court of Appeals reversed a judgment for the plaintiff in accordance with *Frederick & Herrud*. In short, reconsideration of the ERISA preemption issue occurred in both cases as a direct result of the United States Supreme Court's mandate in *Frederick & Herrud*. Thus, for the reasons that follow, we hold that the issues were preserved for our review.

First, the ERISA implications in these cases were considered after plaintiff received favorable judgments in

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20 **See also *Federal Kemper*, n 14 *supra*.**

both cases. Accordingly, plaintiff was not required to take any steps for the preservation of its ERISA issue concerning the federal common law.[21] Second, the federal courts have made clear their preference for consideration of ERISA issues despite a party's failure to so frame the issues at the commencement of proceedings.[22] In addition, the federal issues were incorporated either directly or indirectly at the behest of the United States Supreme Court with instructions to reconsider in light of *FMC Corp*. Moreover, we note that the recent Sixth Circuit cases deal with complaints originally filed in state courts that were later removed on the defendants' motion. Although the cases before us did not take the same procedural route, we discern from the Sixth Circuit cases a preference for consideration.[23] Third, any delay in the treatment of the ERISA issues is directly attributable to their recent development in the federal courts rather than to any dilatory practice on the part of plaintiff or defendants. Accordingly, this Court is persuaded that plaintiff's arguments merit plenary consideration.[24]

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21 See *Washington* v *Lane*, 840 F2d 443, 444-445 (CA 7, 1988)(an appellee may raise any grounds for an affirmance without filing a cross-appeal).

22 See *Miller* v *Metropolitan Life Ins Co*, 925 F2d 979 (CA 6, 1991) (the trial court properly considered ERISA issues despite the plaintiff's total reliance on state law claims in the complaint).

23 See *Auto Club* and *Lincoln Mutual, supra.*

24 Because the issues before us are the subject of federal law, we support our position with federal authority. Were it otherwise, we have at our disposal the rule that an issue may be raised for the first time on appeal where its consideration is necessary to a proper determination of the case. See, e.g., *Joyce* v *Vemulapalli*, 193 Mich App 225, 228; 483 NW2d 445 (1992).

IV

A

The ERISA was signed into law by President Gerald Ford on Labor Day, 1974.[25] As the act's title indicates, its primary purpose is the protection of employees' pension rights for plans created under the auspices of the ERISA.[26] The act also attempts to regulate "employee welfare benefit plan[s]."[27] The ERISA's regulation of health and welfare benefit plans is, however, much less expansive than its pension-oriented counterparts.[28] The lack of statutory guidance covering health and welfare plans has led to the development of a "federal common law" intended to supplement the provisions of the ERISA.[29]

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25 PL No 93-406, tit I, § 2, 88 Stat 832 (codified at 29 USC 1001 *et seq.*).

26 See, generally, Brummond, *Federal preemption of state insurance regulation under ERISA*, 62 Iowa L R 57 (1976).

27 29 USC 1002(1) defines the term "employee welfare benefit plan" as

> any plan, fund, or program which was heretofore or is hereafter established . . . for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services . . . . [Emphasis added.]

28 See Gregory, *The scope of ERISA preemption of state law: A study in effective federalism*, 48 U Pitt L R 427, 432-433 (1987); Boggess, *ERISA's silent pre-emption of state employee welfare benefit laws: The perils of relying upon the road less traveled*, 1992 Det Col L R 745, 747, 752.

29 See *Pilot Life Ins Co* v *Dedeaux*, 481 US 41; 107 S Ct 1549; 95 L Ed 2d 39 (1987). See also *Franchise Tax Bd* v *Construction Laborers*

(*concluded on page A-15*)

The foregoing discussion presupposes preemption of state law, which thereby creates the void to be filled by the federal common law. In the case of state insurance regulation, preemption is made more difficult by the existence of over a century's deference by the federal courts to states' expertise in the insurance field. In *Paul* v *Virginia*, 75 US (8 Wall) 168, 183; 19 L Ed 357 (1868), the United States Supreme Court ruled that the issuance of insurance policies was "not a transaction of commerce" and was therefore "governed by the local law." The United States Supreme Court reversed its position, however, in *United States* v *South-Eastern Underwriters Ass'n*, 322 US 533; 64 S Ct 1162; 88 L Ed 1440 (1944). In response, in 1945, Congress passed the McCarran-Ferguson Act.[30] Section 1011 provides:

> Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

Section 1012 further provides:

> (a) The business of insurance . . . shall be subject to the laws of the several States

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(*continued from page A-14*)

Vacation Trust, 463 US 1, 24 n 26; 103 S Ct 2841; 77 L Ed 2d 420 (1983)(the "ERISA's legislative history indicates that . . . a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans")(quoting Senator Javits, 120 Cong Rec 29942 [1974]), *In re White Farm Equipment Co*, 788 F2d 1186, 1191 (CA 6, 1986)("Congress intended to establish employee benefit plan regulation as an exclusive federal concern, with federal law to apply exclusively, even where ERISA itself furnishes no answer").

30 15 USC 1011 *et seq.*

which relate to the regulation . . . of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance . . . .

The term "business of insurance" is undefined by the McCarran-Ferguson Act.

In contradistinction the preemption provisions of the ERISA, 29 USC 1144(a), (b)(2)(A) and (B), which are known as the preemption, savings, and deemer clauses, respectively, provide:

(a) Except as provided in subsection (b) of this section, *the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan* described in section 1003(a) of this title and not exempt under section 1003(b) . . . .

* * *

(b)(2)(A) Except as provided in subparagraph (B), *nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.*

(b)(2)(B) *Neither an employee benefit plan described in section 1003(a) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other in-*

> *surer*, bank, trust company, or investment company *or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts*, banks, trust companies, or investment companies. [Emphasis added.]

Evaluation of the issues before us requires us to reconcile these two seemingly conflicting provisions. We begin with a discussion of several United States Supreme Court cases that foreshadow what we believe will become the "federal common law" in this matter.[31]

B

In *Alessi* v *Raybestos-Manhattan, Inc*, 451 US 504; 101 S Ct 1895; 68 L Ed 2d 402 (1981), the United States Supreme Court concluded that a New Jersey statute forbidding *pension* plans from offsetting retirement benefits by amounts equal to workers' compensation awards was preempted by the ERISA and therefore had no effect on reduction provisions in ERISA pension plans. According to the Court, "private parties, not the Government, control the level of benefits . . . ." *Id.* at 511. Although the state law ostensibly attempted to regulate workers' compensation benefits and not pension plans, the Court viewed it as a law "relate[d] to pension plans" that attempted to directly control the method by which an ERISA pension plan calculated its benefit payments. *Id.* at 524. In considering Congress' intent regarding pos-

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31 As the more recent federal cases make clear, the issues considered today are within the province of federal law. See *Auto Club* and *Lincoln Mutual, supra*. Because the Sixth Circuit Court of Appeals has not decided the conflicting clauses issue, and because the district courts are split on its resolution, this Court is called upon to anticipate the ultimate federal position.

sible "integration" of retirement benefits with other forms of compensation, the Court noted Congress' acknowledgement of "the tension between the primary goal of benefiting employees and the subsidiary goal of containing pension costs." *Id.* at 514-515.[32]

In a case involving employee benefits rather than pension benefits, the Court found ERISA preemption of New York's Human Rights Law, which would have required ERISA plans to provide benefits for pregnancy leave at a time when that was not required by federal law. *Shaw* v *Delta Air Lines, Inc*, 463 US 85; 103 S Ct 2890; 77 L Ed 2d 490 (1983). The Court noted Congress' intent that the term "relates to" in 29 USC 1144(a) be afforded a broad interpretation so that state laws attempting to govern matters not *specifically* covered by the ERISA were still subject to preemption. *Id.* at 98. A unanimous Court agreed that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. Regarding New York's Disability Benefits Law, the Court

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32 **The following excerpt from the committee report on the proposed ERISA bill makes clear the delicate balance between individual and collective employee benefits:**

> **On the one hand, the objective of the Congress in increasing social security benefits might be considered to be frustrated to the extent that individuals with low and moderate incomes have their private retirement benefits reduced as a result of the integration procedures. On the other hand, your committee is very much aware that many present plans are fully or partly integrated and that elimination of the integration procedures could substantially increase the cost of financing private plans. *Employees, as a whole, might be injured rather than aided if such cost increased resulted in slowing down the growth or perhaps even eliminat[ing] private retirement plans.* [Quoting] HR Rep No 93-807, p 69 (1974), reprinted in 2 Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print compiled for the Senate Committee on Labor and Public Welfare) 3189 (1976). [451 US 515. Emphasis added.]**

concluded that, while plans whose benefits are entirely coextensive with provisions required by state law may be excepted from ERISA preemption,[33] that is not the case where the plan in question is a multibenefit plan. *Id.* at 107. In other words, plans whose sole purpose is to comply with state law are not entitled to ERISA preemption in an attempt to avoid the effects of state law, whereas plans with coverage in excess of state requirements are the proper subject of preemption. The piecemeal applicability of state and federal law that would occur if sections of an ERISA plan, rather than the plan itself, were subject to state control under § 1003(b)(3) was characterized as an "administrative impracticality." *Id.*

Several years after the United States Supreme Court defined the ERISA preemption clause in *Alessi* and *Shaw*, it had occasion to consider the effect of the saving clause[34] in a case involving state law governing an insurance matter. *Metropolitan Life Ins Co* v *Massachusetts*, 471 US 724; 105 S Ct 2380; 85 L Ed 2d 728 (1985). Massachusetts law required health insurers, including ERISA health plans, to provide minimum health care benefits. The Court held that the saving clause deserved as broad an interpretation as the preemption clause that saves state-mandated laws *regulating insur-*

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33 **29 USC 1003(b) provides:**

> **The provisions of this subchapter shall not apply to any employee benefit plan if —**
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> * * *
>
> **(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance law.**

34 **29 USC 1144(b)(2)(A).**

ance.[35] *Id.* at 740, 746. The Court further engaged in a restrictive reading of the deemer clause, concluding that it only removed from the purview of the savings clause state insurance regulations "that apply *directly* to benefit plans . . . ." *Id.* at 741 (emphasis added). This distinction would permit indirect regulation of insured ERISA plans but not of self-funded plans. *Id.* at 747.

In *Fort Halifax Packing Co Inc* v *Coyne*, 482 US 1; 107 S Ct 2211; 96 L Ed 2d 1 (1987), the Court recognized the ERISA purpose of avoiding variable state regulation that would pose administrative burdens on employers. The majority distinguished between state laws regulating certain *benefits* to be provided by employers and those regulating ERISA *plans*. *Id.* at 7-8. According to the majority, state regulation of a plan would subject employers to undesirable administrative burdens while regulation of a benefit, here a one-time severance payment, would not have any radical effect on the administration of the ERISA plan involved. *Id.* at 10-14. Because the effect of Maine's severance pay law would only have a one-time effect on the ERISA plan, it did not truly "relate to" the plan and it therefore was not preempted by 29 USC 1144(a). *Id.* at 23. Four justices dissented on the basis of their belief that regulation requiring the payment of specific benefits "clearly 'relate[s] to' benefit

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35 **To determine whether a law qualifies as one regulating the "business of insurance," and thereby avoids preemption under the authority of the McCarran-Ferguson Act, see n 25 *supra* and accompanying text, and the saving clause, its ERISA counterpart, three criteria must be considered:**

> **[*F*]*irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry. [471 US 743, quoting *Union Labor Life Ins Co* v *Pireno*, 458 US 119, 129; 102 S Ct 3002; 73 L Ed 2d 647 (1982) Emphasis in original.]**

plans" as contemplated by the ERISA preemption provision. 482 US 24 (White, J., dissenting).[36]

The import of the preemption and the saving clauses having been defined in the previous cases, the Court turned its attention to the deemer clause in *FMC Corp, supra*.[37] The plaintiff in *FMC Corp* was an employer with a self-funded ERISA plan who sought recoupment of medical benefits paid on behalf of an employee's daughter. The subrogation clause in the health plan provided for reimbursement out of any sums collected by the benefits recipient in a liability action against a third party. The defendant asserted that Pennsylvania's antisubrogation statute obviated any duty to reimburse the plaintiff.[38]

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36 The dissent notes that the majority's view would permit state regulation of a benefit as long as the regulation would not require the creation of an administrative scheme. 482 US 24. To the extent that the dissenters are correct, the majority holding would appear to be inconsistent with the *Shaw* holding, which provides in part that "[a] State may require an employer to maintain a disability plan complying with state law as a separate administrative unit." 463 US 108.

37 For a discussion of the exceptions to preemption for certain state laws, see, generally, anno: *Construction and application of preemption exception, under Employee Retirement Income Security Act (29 USC 1001 et seq., for state laws regulating insurance, banking, or securities (29 USC 1144[b][2])*, 87 ALR Fed 797.

38 Section 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law provides:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits paid or payable . . . under section 1719 . . . . [75 Pa Cons Stat Ann 1720.]

Section 1719(a) in turn provides:

> Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits . . . shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits . . . . [75 Pa Cons Stat Ann 1719(a).]

Consideration of the preemption issue in this case led to the most succinct explanation of the preemption, saving, and deemer clauses to date.

> The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that "regulat[e] insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts. [498 US 58.]

Citing *Shaw*, the *FMC Corp* majority concluded that Pennsylvania's antisubrogation statute related to the ERISA plan. *Id.* at 58-59. The Court also cited *Alessi* and *Fort Halifax*, *supra*, for the proposition that the Court "ha[d] not hesitated to apply ERISA's pre-emption clause to state laws that risk subjecting plan administrators to conflicting state regulations." *Id.* at 59. Furthermore, the antisubrogation law fell within the purview of the saving clause because it "directly control[led] the terms of insurance contracts by invalidating any subrogation provisions that they contain" and "[i]t does not merely have an impact on the insurance industry; it is aimed at it." *Id.* at 61.

On the issue of the deemer clause and its effect on the Pennsylvania statute, the majority opined:

> [S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed

> toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer. [*Id.*]

As noted earlier, the ERISA's primary purpose is to protect employees' pension rights from abuse.[39] Another clear purpose is to ensure the minimization of costs associated with the establishment of voluntary pension plans.[40] *Alessi, supra* at 515. The policy behind ERISA preemption in the case of health and welfare benefits plans is the same. However, the manifestation of this policy has differed slightly, perhaps because there was less statutory directive and, hence, more likelihood of varying interpretation occurring under case-

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39 See, generally, Gregory, n 28 *supra* at 443-448, 454 and the authority cited therein.

40 Employers are not required to establish pension funds for employees under the ERISA. Once such plans are established, however, the ERISA safeguards their proper maintenance. See Gregory, n 28 *supra* at 448.

by-case treatment. Nevertheless, we are persuaded that what must ultimately solidify the federal common law on the multitude of ERISA issues is Congress' intent to prevent "[a] patchwork scheme of regulation [that] would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."[41] *Fort Halifax*, *supra* at 11. Moreover, what the recent federal interpretation of the deemer clause makes abundantly clear is that the majority of conflicts between state and federal law and policy will be decided by the federal courts.[42] The only qualifier to ERISA preemption of state insurance law is indirect regulation via state laws governing insurance companies that assume plan liability in exchange for premiums paid by an ERISA plan. *FMC Corp*, *supra* at 61.

C

The courts of this state have adhered to an interpretation of MCL 500.3109a; MSA 24.13109(1) that requires a finding that a no-fault insurer is secondarily liable for insurance coverage where there is any form of health care coverage and where the insurers both sought to escape liability through the use of competing coordina-

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41 The ERISA neither requires the establishment of employee health and welfare benefits plans nor the funding of such plans once established. See Gregory, n 28 *supra* at 449, n 76 and the authority cited therein.

42 In *Metropolitan Life*, *supra* at 739-747, the United States Supreme Court read the saving clause broadly to preserve state regulation of insurance. This position, however, was retracted in part by FMC Corp, *supra* at 64, wherein the Court majority concluded that "the language of the deemer clause [was] either coextensive with or broader, not narrower, than that of the saving clause."

tion-of-benefits clauses.[43] See, e.g., *Federal Kemper Ins Co* v *Health Ins Administration, Inc* 424 Mich 537, 546; 383 NW2d 590 (1986). The policy behind MCL 500.3109a; MSA 24.13109(1) is avowedly to eliminate duplicative recovery by an insured from both a health insurer and a no-fault insurer, and to contain or reduce no-fault and health care insurance costs.

In *Federal Kemper*, this Court reached the conclusion that the health insurance provider was primarily responsible for payments without considering ERISA preemption although it appears that the defendant plan was an ERISA plan. However, at the time *Federal Kemper* was decided, the federal position on state regulation of insurance law had long been one of deference to state expertise. See, e.g., *Metropolitan Life*, *supra* at 742-745 and ns 17-22. While the United States Supreme Court and the Sixth Circuit Court of Appeals have recently concluded that the conflict involved here is to be determined by the federal common law, exactly what that law should be is the subject of differing interpretations between the two federal district courts in this state. It is to this dilemma that we now turn.

D

At first blush, it would appear that we are confronted with conflicting public policies: one reflecting federal concern over the continued existence and growth of ERISA health and welfare benefits plans and the other reflecting state concern over spiraling costs in the context of automobile accidents involving no-fault insurers. Our inquiry is further complicated by the fact that the

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43 For a discussion of conflicting "excess" or coordination-of-benefits clauses, see, generally, anno: *Apportionment of liability between liability insurers each of whose policies provides that it shall be "excess" insurance*, 69 ALR2d 1122; 44 Am Jur 2d, Insurance, §§ 1788-1791, pp 776-780; 16 Couch, Insurance, 2d § 62:79, pp 548-550.

federal policy also accrues to the benefit of the citizens of this state. Federal law requires neither the establishment of health and welfare benefits plans nor minimum funding requirements once the plans are established. State interference in the realm of ERISA benefits could very well be the deciding factor in an employer's decision to establish or adequately fund a health and welfare benefits plan.

Congress' first move in its effort to prevent regulation that would frustrate the purposes behind the ERISA was the enactment of the preemption clause.[44] By its action, Congress made clear its intention to make federal law and policy supreme in the ERISA context. Its effort was complicated, however, by the passage of the McCarran-Ferguson Act.[45] In recognition of historic federal respect for the primacy of state law in areas traditionally dominated by state regulation, i.e., insurance, banking, and securities, Congress promulgated the ERISA saving clause.[46] Nonetheless, Congress removed from the reach of state regulation pension or health and welfare benefits plans established under the ERISA pursuant to the deemer clause,[47] although it did not specifically forbid any state regulation of insurance, banking, or securities law. Despite the existence of these clauses, workable guidelines in the context of health and welfare benefits plans have developed slowly.

In *Alessi*, the United States Supreme Court held that state law was preempted to the extent that it attempted to control the terms of an ERISA pension plan. In *Shaw*,

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44 **29 USC 1144(a).**

45 **See n 30.**

46 **29 USC 1144(b)(2)(A).**

47 **29 USC 1144(b)(2)(B).**

the Court interpreted the preemption clause to prevent state regulation of welfare benefits in multibenefit ERISA plans, while noting the danger of the administrative difficulty that would result from piecemeal state legislation. Next, the Court defined the saving clause to preserve state law mandating certain minimum benefits in an ERISA plan as long as the state law regulates insurance law rather than an ERISA plan directly. *Metropolitan Life, supra*. Although the Court majority in *Fort Halifax* concluded that a one-time severance payment required by state law did not relate to an ERISA plan so that it was preempted, the majority did reiterate the ERISA purpose of avoiding variable state regulation that would pose administrative burdens to plan administrators. Finally, the Court concluded in *FMC Corp* that states could not regulate the contractual terms of ERISA benefits plans in cases of self-funded plans. ERISA plans, however, are subject to indirect regulation in a case in which a state regulates an insurance carrier that has contracted with the plans to provide coverage for claims made on the plans.

Building upon these cases, the Sixth Circuit in *Auto Club* and *Lincoln Mutual, supra*, concluded that MCL 500.3109a; MSA 24.13109(1) was preempted by the ERISA. Moreover, the fact that the plans purchased stop-loss insurance did not effect preemption because § 3109a, as interpreted by cases such as *Federal Kemper, supra*, would have a direct regulatory effect on the ERISA plans. *Lincoln Mutual*, 970 F2d 210. Now we must anticipate what the federal common law should be.

We take our guidance from the Eastern District's decision in *Lincoln Mutual* on remand because we believe that it best reconciles the tension between state and federal policy. We agree with that court's conclusion that the COB clause in an ERISA policy must be given its

meaning without the creation of any artificial conflict based upon MCL 500.3109a; MSA 24.13109(1). Therefore, because both plans provide that no-fault insurance is primary where the potential for duplication of benefits occurs, we hold that the ERISA plans' terms control. The no-fault insurer, ACIA, is primarily liable for the benefits at issue. Although the Michigan statute purports to regulate insurance and not ERISA plans, we conclude that it has a direct effect on the administration of the plans in these cases because it would virtually write a primacy of coverage clause into the plans. This is the type of state regulation that would lead to administrative burdens that the historical progression of federal cases recounted earlier forbids.

Moreover, and of equal importance, we are persuaded that the federal policy furthers the state interest of fostering the existence of health and welfare benefits plans for its citizens. Thus, the perceived conflict between state and federal policy is not as marked as plaintiff would have us believe. Earlier we noted that there is no law requiring the establishment or funding of ERISA health and welfare benefits plans. We are also unaware of any state law requiring similar protection. Therefore, there is a considerable state interest in facilitating the creation and voluntary funding of such plans, especially in cases in which there is no automobile no-fault or other insurance to provide benefits. For these reasons, we conclude that MCL 500.3109a; MSA 24.13109(1) does not reach an ERISA plan with a COB clause where that clause is unambiguous.

V

Plaintiff also argues in both cases that, in the event the federal common-law issue is decided adversely to its position, the federal common law would not apply to any amounts that are the subject of "stop-loss" insur-

ance. Again, under the facts of this case, we must disagree.

In *FMC Corp, supra*, the United States Supreme Court ruled that self-funded health and welfare benefits plans were not insurance companies pursuant to the language of the deemer clause and were therefore not subject to regulation by state insurance law. On the other hand, state regulation of insurance companies that would only *indirectly* effect ERISA plans is permitted. 498 US 61. We must therefore distinguish between what is "direct" and what is "indirect" state regulation of these ERISA plans.

Under the terms of the Frederick plan, defendant retains the duties of administrator.[48] The Pentwater plan also provides that defendant Pentwater is the plan administrator.[49] Thus, MCL 500.3109a; MSA 24.13109(1) and the cases interpreting it would have the effect of removing all discretion from the plan administrators on the issue whether to pay health benefits when other sources of payment exist. We are persuaded that this qualifies as a direct rather than an indirect effect on the plans.

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48 Under § 14 of the plan, employees requesting benefits pick up forms from the employer. In §§ 15 and 16, the plan covers procedures for denial of claims and for the appeal-of-denials procedure. Finally, § 26, subsection 5 provides that the plan is administered by "Frederick & Herrud, Inc." There is no indication that defendant Frederick & Herrud delegates any authority regarding claims made on the plan.

49 Although Pentwater set up a trust as its way of setting aside sufficient funds, that trust provides in art II, § 2.1 that the trustee "shall, from time to time *at the direction of the Plan Administrator or the Corporation*, make payments out of the Trust Fund . . . ." Moreover, art V, § 5.2 of the Pentwater plan defines the plan administrator as "The Employer." In addition, the "stop-loss" policy issued to defendant by Safeco provides that it will reimburse defendant for benefits "*paid for covered persons under your plan.*" Accordingly, all discretion regarding the payment or denial of claims remains with defendant.

This very point was recognized in *Lincoln Mutual*, 970 F2d 210. Although the Sixth Circuit did not invalidate the state law, the court concluded that the direct effect required preemption under *FMC Corp* so that the issue had to be decided as a matter of federal law. For the policy reasons stated previously, we conclude that the existence of "stop-loss" insurance is irrelevant in this case because any regulation of it would have a significant effect on the administration of the ERISA plans involved.[50]

VI
CONCLUSION

In sum, we conclude that subrogation is permitted under the ERISA and that the issues considered here were preserved for this Court's review. Further, we hold that an unambiguous COB clause in an ERISA health and welfare benefit plan must be given its plain meaning despite the existence of a similar clause in a no-fault policy because any conflict created by the requirements of MCL 500.3109a; MSA 24.13109(1) and this Court's interpretation of the statute would have the direct effect of dictating the terms of the ERISA plans. To the extent that our decision in *Federal Kemper* is inconsistent with our holding today, it is overruled. We emphasize, however, that the primacy of health care coverage over that in a no-fault policy continues in Michigan jurisprudence in all cases not within the purview of this narrow holding. We also conclude that the existence of stop-loss insurance has no bearing on the outcome here because discretion to pay

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50 See *Wolverine Mutual Ins Co* v *Rospatch Corp Employee Benefit Plan*, 195 Mich App 302, 308, n2; 489 NW2d 204 (1992)("[A]n insurance policy that merely protects the plan from disastrous consequences, but does not directly insure the obligations owed to the plan members, does not affect the plan's status as self-insured").

or deny claims remains in the ERISA plan and was never delegated to the insurers.

Affirmed.

CAVANAGH, C.J., and LEVIN, BRICKLEY, BOYLE, GRIFFIN, and MALLETT, JJ., concurred with RILEY, J.

ORDER

(State of Michigan — Supreme Court)

(Entered November 2, 1992)

(AUTO CLUB INSURANCE ASSOCIATION, Subrogee of Ali Chehab, Faysal Masloum, Houhad Jamil Bazzi, Hussein E. Habab, Nasri Jomaa, Ali K. Hashem and Sami M. Alaouie, Plaintiff-Appellant, v FREDERICK & HERRUD, INC., Self-Funded Employee Health Benefit Plan, Defendant-Appellee — SC: 93816; CoA: 135974; LC: 82-246269-CK)

Michael F. Cavanagh, Chief Justice;
Charles L. Levin, James H. Brickley, Patricia J. Boyle, Dorothy Comstock Riley, Robert P. Griffin, Conrad L. Mallett, Jr., Associate Justices.

On order of the Court, the application for leave to appeal is considered, and it is GRANTED.

We further ORDER that this case be argued and submitted to the Court together with the case of *Auto Club Ins Ass'n* v *Pentwater Wire Products, Inc* (Docket No. 93925), at such future session of the Court as both cases are ready for submission.

(*Certification Omitted*)

OPINION (On Remand)
-191 MICH APP 471-

(State of Michigan — Court of Appeals)

(Submitted December 26, 1990;
Decided October 8, 1991)

(AUTO CLUB INSURANCE ASSOCIATION v FREDERICK & HERRUD, INCORPORATED (ON REMAND) — Docket No. 135974)

Before: GRIBBS, P.J., and DOCTOROFF and REILLY, JJ.

PER CURIAM

This case has been remanded to us by the United States Supreme Court for our reconsideration in light of *FMC Corp* v *Holliday*, 498 US ___, 111 S Ct 403; 112 L Ed 2d 356 (1990). We reverse.

This matter is before us for the third time. This litigation involved a dispute between plaintiff and defendant regarding which of them should bear primary responsibility for medical and related expenses incurred by several employees of defendant. These employees were covered by no-fault insurance policies issued by plaintiff and by a self-funded health and accident benefit plan operated by defendant. In our initial decision, we reversed the lower court's order holding each party responsible for payment of one-half the benefits owed to the insureds and concluded that the Legislature intended the health and accident coverage to be primary and the no-fault coverage to be secondary. We remanded this case for entry of judgment and determination of liability consistent with our opinion. *Auto Club Ins Ass'n* v *Frederick & Herrud, Inc*, 145 Mich App 722; 377 NW2d 902 (1985).

Following remand to the circuit court, defendant moved for leave to amend its answer to add the affirma-

tive defense that plaintiff's state claim was preempted by the Employee Retirement Income Security Act (ERISA), 29 USC 1144(a). The circuit court denied the motion to amend, finding no newly discovered facts and undue delay in bringing the motion. Defendant then moved for summary disposition, asserting that the ERISA deprived the state court of subject-matter jurisdiction of the dispute. The circuit court denied defendant's motion for summary disposition and entered judgment for plaintiff. Defendant appealed the circuit court decision to this Court.

This Court issued a published opinion noting that the issue whether MCL 500.3109a; MSA 24.13109(1) was preempted by the ERISA had been resolved in *Northern Group Services, Inc* v *Auto Owners Ins Co*, 833 F2d 85 (CA 6, 1987), cert den 486 US 1017 (1988):

> We believe the Sixth Circuit's construction of the pertinent ERISA provisions is persuasive and, as a federal court construing federal law, its decision is controlling precedent. [175 Mich App 412, 418-419; 438 NW2d 320 (1989).]

Defendant's application for leave to appeal was denied by our Supreme Court, 433 Mich 902 (1989). However, in November 1990, the United States Supreme Court released *FMC* v *Holliday, supra*. Shortly after its decision in *FMC*, the United States Supreme Court granted certiorari in this case, vacated our decision, and remanded this matter to us for reconsideration in light of *FMC*. __ US __; 111 S Ct 552; 112 L Ed 2d 559 (1990).

In *FMC*, the Court ruled that the ERISA preempted a Pennsylvania law precluding self-funded employee benefit plans from exercising subrogation rights against a claimant's tort recovery:

> [I]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and

> its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it. [498 US ___; 112 L Ed 2d 368.]

Because the plan in this case is self-insured, it now appears to us that, contrary to the decision in *Northern Group Services, supra*, state regulation is precluded under the ERISA. We note, too, that other courts have concluded that *Northern Group Services* was effectively overruled by the United States Supreme Court decision in *FMC*. See *Allstate Ins Co* v *Michigan Carpenters' Council Health & Welfare Fund*, 760 F Supp 665 (WD Mich, 1991); *Lincoln Mutual Casualty Co* v *Lectron Products, Inc*, 1991 WESTLAW 33558 (ED Mich, February 27, 1991).

Plaintiff's newly discovered claim that the ERISA plan in this case is not self-funded need not be considered because this issue was not raised before the trial court. *Peisner* v *Detroit Free Press, Inc*, 421 Mich 125, 129, n 5; 364 NW2d 600 (1984). In any case, we are convinced that purchase of stop loss insurance coverage does not transform a benefit plan into an insured plan for purposes of the ERISA. See *FMC*, 498 US ___; 112 L Ed 2d 366.

Reversed.

ORDER

(United States of America — Supreme Court)

United States of America, ss:

THE PRESIDENT OF THE UNITED STATES OF AMERICA

To the Honorable the Judges
of the Court of Appeals of Michigan,

GREETINGS:

WHEREAS, lately in the Court of Appeals of Michigan, there came before you a cause between Auto Club Insurance Association, Plaintiff-Appellee, and Frederick & Herrud, Incorporated, Defendant-Appellant, No. 96693, wherein the judgment of the said Court of Appeals was duly entered on sixth day of March, 1989, as appears by an inspection of the petition for a writ of certiorari.

AND WHEREAS, in the 1990 Term, the said cause having been submitted to the SUPREME COURT OF THE UNITED STATES on the said petition for writ of certiorari, and the Court having granted the said petition.

ON CONSIDERATION WHEREOF, it was ordered and adjudged on December 3, 1990, by this Court that the judgment of the above court in this cause was vacated with costs, and that this cause is remanded to the Court of Appeals of Michigan for further consideration in light of *FMC Corporation* v. *Holliday*, 498 U.S. ___ (1990).

IT IS FURTHER ORDERED, that the petitioner, Thorn Apple Valley, Inc., recover from Auto Club Insurance Association, etc., Three Hundred Dollars ($300.00) for its costs herein expended.

NOW, THEREFORE, THE CAUSE IS REMANDED to you in order that such proceedings may be had in the said

cause, in conformity with the judgment of this Court above stated, as accord with right and justice, and the Constitution and laws of the United States.

Witness the Honorable WILLIAM H. REHNQUIST, Chief Justice of the United States, the 7th day of January in the year of our Lord one thousand nine hundred and ninety-one.

/s/ _____

Clerk of the Supreme Court
of the United States

ORDER

(United States of American — Supreme Court)

(Dated December 3, 1990)

(Thorn Apple Valley, Inc., Petitioner, v. Auto Club Insurance Association, etc. — No. 89-1125)

ON WRIT OF CERTIORARI to the Court of Appeals of Michigan.

THIS CAUSE having been submitted on the petition for writ of certiorari and response thereto,

ON CONSIDERATION WHEREOF, it is ordered and adjudged by this Court that the judgment of the above court in this cause is vacated with costs, and that this cause is remanded to the Court of Appeals of Michigan for further consideration in light of *FMC Corporation* v. *Holliday*, 498 U.S. ___ (1990).

IT IS FURTHER ORDERED that the petitioner, Thorn Apple Valley, Inc., recover from Auto Club Insurance Association, etc., Three Hundred Dollars ($300.00) for its costs herein expended.

December 3, 1990

Clerk's costs: $300.00

ORDER

(State of Michigan — Supreme Court)

(Entered November 1, 1989)

(AUTO CLUB INSURANCE ASSOCIATION, formerly known as DAIIE, Subrogee of Ali Chehab, Faysal Masloum, Houhad Jamil Bazzi, Hussein E. Habab, Nasri Jomaa, Ali K. Hashem and Sami M. Alaouie, Plaintiff-Appellee, v FREDERICK & HERRUD, INCORPORATED, a corporation, Defendant-Appellant — SC: 85771; CoA: 96693; LC: 82-246269-CK)

Dorothy Comstock Riley, Chief Justice;
Charles L. Levin, James H. Brickley, Michael F. Cavanagh, Patricia J. Boyle, Dennis W. Archer, Robert P. Griffin, Associate Justices.

On order of the Court, the application for leave to appeal is considered, and it is DENIED, because we are not persuaded that the questions presented should be reviewed by this Court.

(*Certification Omitted*)

OPINION
-175 MICH APP 412-

(State of Michigan — Court of Appeals)

(Submitted May 10, 1988; Decided March 6, 1989)

(AUTO CLUB INSURANCE ASSOCIATION v FREDERICK & HERRUD, INCORPORATED)

Before: GRIBBS, P.J., and MAHER and J. L. Banks*, JJ.

J. L. BANKS, J.

Defendant appeals as of right from a judgment entered in favor of plaintiff on November 3, 1986, and from interlocutory orders denying defendant's motion for leave to file a first amended answer and denying defendant's motion for summary disposition.

This is the second time this case is before this Court. The facts are detailed in *Auto Club Ins Ass'n* v *Frederick & Herrud, Inc,* 145 Mich App 722; 377 NW2d 902 (1985). This litigation involves a dispute between plaintiff and defendant as to which of them shall bear primary responsibility for medical and related expenses incurred by seven employees of defendant. These employees were covered by no-fault insurance policies issued by plaintiff. In our prior decision, we reversed the lower court's order holding each party responsible for payment of one-half the benefits owed to the insureds. 145 Mich App 734. Based on our review of the legislative history behind MCL 500.3109a; MSA 24.13109(1), we concluded that the Legislature, in providing that no-fault insurers were required to offer coordination of benefits options to their insureds, intended the health and accident insurance coverage to be pri-

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* **Circuit Judge, sitting on the Court of Appeals by assignment.**

mary and the no-fault coverage to be secondary. 145 Mich App 727-732.[1] We remanded this case for entry of judgment and determination of liability consistent with our opinion. 145 Mich App 734.

Following remand to the circuit court, defendant moved for leave to amend its answer to add the affirmative defense that plaintiff's state claim was preempted by the Employee Retirement Income Security Act (ERISA), 29 USC 1144(a). The circuit court denied the motion to amend, finding no newly discovered facts and undue delay in bringing the motion. Defendant then moved for summary disposition, asserting that ERISA deprived the state court of subject matter jurisdiction over the dispute. The circuit court denied defendant's motion for summary disposition and entered judgment for plaintiff in the amount of $27,911.33 (reimbursement in the amount of $16,560 plus statutory interest and costs).

In this appeal defendant asserts that the trial court erred in denying its motion to amend its answer and in denying its motion for summary disposition. Defendant additionally argues that plaintiff's state claim is preempted by ERISA. While the circuit court did not consider the merits of the issue, and while ordinarily this Court will not review issues not first considered by the trial court, we choose to review the merits of the preemption issue. Our election to review this issue is made in the interests of justice, in recognition of the importance of the issue and the probability that it will again arise in future litigation, and because our decision on this issue renders moot the other issues presented in

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[1] **Our construction of the statute on this issue was approved and adopted by the Michigan Supreme Court in *Federal Kemper Ins Co, Inc* v *Health Ins Administration, Inc*, 424 Mich 537; 383 NW2d 590 (1986).**

this appeal. *DeWitt Twp* v *Clinton Co*, 113 Mich App 709, 713; 319 NW2d 2 (1982).

Section 514(a) of ERISA provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975. [29 USC 1144(a).]

It is undisputed that defendant's employee benefit plan[2] is a plan within the broad scope of ERISA and subject to § 514(a). However, under ERISA, certain types of state laws are "saved" from federal preemption:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. [29 USC 1144(b)(2)(A).]

The Michigan no-fault insurance act is a state act which regulates insurance. However, the saving clause of 29 USC 1144(b)(2)(A) is limited by 29 USC 1144(b)(2)(B), commonly called the "deemer" clause, which provides:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt

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2 Defendant suggests that plaintiff, by filing suit against defendant corporation instead of the employee benefit plan, has sued the wrong party. Defendant, by failing to timely or properly raise this issue in the trial court, has waived any objection to being named as party defendant. *Kotesky* v *Davis*, 355 Mich 536, 540; 94 NW2d 795 (1959). Furthermore, it is not necessarily correct that the corporation was not a proper defendant. *Ombrello* v *Montgomery Ward Long Term Disability Trust*, 163 Mich App 816, 824; 415 NW2d 658 (1987), lv den 430 Mich 854 (1988).

> under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Defendant argues that its employee benefit plan is a self-funded plan, i.e., the benefits are paid by the plan itself without involvement by an outside insurance company and that as a self-funded plan it is not subject to the insurance laws of Michigan and accordingly is not "saved" from preemption under 514. Defendant's construction of the ERISA preemption, saving, and deemer clauses was adopted by a panel of this Court in *State Farm Mutual Automobile Ins Co* v *CA Muer Corp*, 154 Mich App 330; 397 NW2d 299 (1986). One of the cases cited in *CA Muer Corp was Northern Group Services, Inc* v *State Farm Mutual Automobile Ins Co*, 644 F Supp 535 (ED Mich, 1986). Subsequent to issuance of the panel's decision in *CA Muer Corp*, the Sixth Circuit Court of Appeals issued its opinion in *Northern Group Services, Inc* v *Auto-Owners Ins Co*, 833 F2d 85 (CA 6, 1987), cert den ___ US ___; 108 S Ct 1754; 100 L Ed 2d 216 (1988), reversing the Eastern District Court's decision.

The precise issue presented in *Northern Group Services* was whether § 3109a of the Michigan no-fault automobile insurance act, which requires coordination of benefits and state court interpretation of the provision making no-fault coverage secondary to other health and accident coverage, is preempted by conflicting ERISA

provisions. In order to determine whether the Michigan law "regulates insurance" and thus falls within the saving provision, the Sixth Circuit followed the analysis set forth in *Metropolitan Life Ins Co* v *Massachusetts*, 471 US 724; 105 S Ct 2380; 85 L Ed 2d 728 (1985), and *Pilot Life Ins Co* v *Dedeaux*, 481 US 41; 107 S Ct 1549; 95 L Ed 2d 39 (1987), which requires examination of whether the practice at issue falls within the meaning of "business of insurance" covered by the *McCarran-Ferguson Act*, 15 USC 1011 *et seq*. That analysis requires consideration of three criteria: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. *Northern Group Services*, 833 F2d 90. The circuit court concluded that the Michigan coordination of benefits law "regulates insurance" and is therefore encompassed by the saving clause. *Id*.

The Sixth Circuit next examined the applicability of the deemer clause to a self-insuring ERISA plan. Specifically, the court considered whether the deemer clause barred state regulation of coordination of benefits under a self-insured plan. 833 F2d 91. The court found that the deemer clause should not be construed as barring all state regulation of self-insured plans per se, but rather, resolution of the issue required consideration of the congressional intent behind the deemer clause, the federal interest in uniformity of administration of ERISA plans, the national policy favoring state primacy in the regulation of insurance, and the legislative intent behind the Michigan statutory benefits provision. The court held:

> Our reading of the savings and deemer clauses thus requires at a minimum that, for the deemer clause to override the savings clause in a given

> case, there must be some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance. When, as here, there is no demonstrated interest in national uniformity and preemption of state law would substantially disrupt a state regulatory scheme generally applicable to both insured and self-insured ERISA plans, as well as to insurers generally, the deemer clause does not bar regulation. To this limited degree, self-insured ERISA plans so regulated are not excluded from the savings clause by the deemer clause; they are thus subject to state insurance regulation pursuant to the savings clause. The Michigan no-fault coordination of benefits rule is the type of insurance regulation of an ERISA plan that is not barred by the deemer clause. [833 F2d 95.]

We believe the Sixth Circuit's construction of the pertinent ERISA provisions is persuasive and, as a federal court construing federal law, its decision is controlling precedent. Defendant asserts it should have been given the opportunity to plead as a defense that plaintiff's claim for reimbursement in accordance with the Michigan coordination of benefits scheme is preempted by conflicting ERISA provisions. Plaintiff's claim, however, is not preempted. *Northern Group Services, Inc*, 833 F2d 95.

Our decision in this case renders it unnecessary to consider the other issues raised on appeal. We affirm the circuit court's judgment entered in favor of plaintiff.

Affirmed.

ORDER OF JUDGMENT

(State of Michigan — Circuit Court — County of Oakland)

(Filed November 3, 1986)

(AUTO CLUB INSURANCE ASSOCIATION, Subrogee of: Ali Chehab, Faysal Masloum, Houhad Jamil Bazzi, Hussein E. Habab, Nasri Jomaa, Ali K. Hashem and Sami M. Alaouie, Plaintiffs, vs. FREDERICK & HERRUD, INCORPORATED, a corporation, Defendant — Case No. 82-246269-CK; Hon. Frederick C. Ziem)

At a session of said Court held in Pontiac, County of Oakland, State of Michigan on NOVEMBER 3, 1986.

PRESENT: HON. [*Frederick C. Ziem*],
CIRCUIT COURT JUDGE.

IT IS HEREBY ORDERED that judgment in the amount of $16,560.00 shall be entered in favor of the Plaintiff herein. Pre judgment interest costs in the amount of $11,311.33 (calculated at 12%) shall also be awarded to Plaintiff. Court costs in the amount of $40.00 shall be awarded to Plaintiff.

IT IS FURTHER ORDERED that a judgment in the amount of $27,911.33 is hereby granted to Plaintiff.

/s/ FREDERICK C. ZIEM
CIRCUIT COURT JUDGE

Approved as to form:

/s/ John Wesley Kline P33150
Attorney for Plaintiff
17515 W. 9 Mile, Suite 1150
Southfield, Michigan 48075

/s/ Bradley T. Raymond [*fz w/permission*] P27952
Attorney for Defendants
20300 West Twelve Mile Road, Suite 200
Southfield, Michigan 48076

Drafted by:
John Wesley Kline P33150
Attorney for Plaintiff
17515 W. 9 Mile, Suite 1150
Southfield, Michigan 48075

(Certification Omitted)

ORDER DENYING DEFENDANT'S MOTION FOR SUMMARY DISPOSITION FOR LACK OF SUBJECT MATTER JURISDICTION AND GRANTING PLAINTIFF'S MOTION FOR ENTRY OF JUDGMENT

(State of Michigan — Circuit Court — County of Oakland)

(Filed October 24, 1986)

(AUTO CLUB INSURANCE ASSOCIATION, formerly known as DAIIE, Subrogee of Ali Chehab; Faysal Masloum; Houhad Jamil Bazzi; Hussein E. Habab; Nasri Jomaa; Ali K. Hashem and Sami M. Alaouie, Plaintiffs, v FREDERICK & HERRUD, INCORPORATED, a corporation, Defendant — Case No. 82-246269-CK; Hon. Frederick C. Ziem)

At a session of said Court held in the Courthouse in the City of Pontiac, County of Oakland, State of Michigan on OCTOBER 24, 1986.

PRESENT: HON. FREDERICK C. ZIEM

Plaintiff having filed a Motion for Entry of Judgment along with a supporting Brief; Defendant having opposed this Motion and having additionally filed a Motion for Summary Disposition for lack of subject matter jurisdiction together with an Affidavit, Exhibits and a supporting Brief; Plaintiff having filed a response to Defendant's Motion for Summary Disposition; and the Court having heard and considered the arguments of counsel on October 1, 1986;

IT IS HEREBY ORDERED that, for the reasons stated by the Court from the bench on October 2, 1986, Defendant's Motion for Summary Disposition for lack of subject matter jurisdiction is hereby denied and Plaintiff's Motion for Entry of Judgment is hereby granted.

/s/ FREDERICK C. ZIEM

Approved as to form:
/s/ JOHN WESLEY KLINE (P33150)
Attorney for Plaintiffs

(*Certification Omitted*)

ORDER DENYING MOTION FOR LEAVE TO FILE FIRST AMENDED ANSWER AND NOTICE OF AFFIRMATIVE DEFENSES

(State of Michigan — Circuit Court — County of Oakland)

(Filed April 15, 1986)

(AUTO CLUB INSURANCE ASSOCIATION, Subrogee of: Ali Chehab; Faysal Masloum; Houhad Jamil Bazzi; Hussein E. Habab; Nasri Jomaa; Ali K. Hashem and Sami M. Alaouie, Plaintiffs, vs. FREDERICK & HERRUD, INCORPORATED, a Corporation, Defendant — Case No. 82-246269-CK; Hon. Frederick C. Ziem)

At a session of said Court held in the City of Detroit [*sic*], County of Wayne [*sic*], and State of Michigan on APRIL 11, 1986.

PRESENT: HON. [*Frederick C. Ziem*],
CIRCUIT COURT JUDGE.

This matter having come on for hearing on Defendant's Motion for Leave to file First Amended Answer & Notice of Affirmative Defenses, the Court having heard arguments of the parties regarding same, and the Court having found that there was undue delay on the part of the Defendant in making said request for late filing;

IT IS THEREFORE ORDERED that the Motion for Leave to File First Amended Answer and Notice of Affirmative Defenses filed by the Defendant is denied.

/s/ FREDERICK C. ZIEM
CIRCUIT COURT JUDGE

Approved as to form: /s/ BRADLEY T. RAYMOND P13435, Attorney for Defendant; Drafted by: John Wesley Kline P33150, Attorney for Plaintiff, 17515 W. 9 Mile, Ste. 1150, Southfield, Michigan 48075

(*Certification Omitted*)

OPINION
–145 MICH APP 722–

(State of Michigan — Court of Appeals)

(Submitted June 10, 1985; Decided September 16, 1985)

(AUTO CLUB INSURANCE ASSOCIATION v FREDERICK AND HERRUD, INC.)

Before: DANHOF, C.J.,
and R. B. BURNS and V. J. BRENNAN, JJ.

DANHOF, C.J.

Defendant appeals as of right from the order of summary judgment entered on June 25, 1984, declaring that plaintiff and defendant were equally responsible for the payment of no-fault benefits to their respective insureds. Plaintiff cross-appeals.

On August 25, 1982, plaintiff brought suit against defendant, alleging that seven named insureds were each insured under a no-fault insurance contract issued by it, which contracts contained "coordination-of-benefits" clauses. Plaintiff was obligated to pay medical benefits for injuries resulting from auto accidents involving the insureds unless the insureds were covered by another source which provided medical benefits. Each insured was also covered by a contract of accident insurance from defendant, which contract specifically provided that it would pay medical benefits for accidental injuries unless the insureds were covered by no-fault insurance, in which case no-fault would be primary.

In its complaint, plaintiff averred that during 1980-1981, each of the insureds sustained injuries in auto accidents and that claims for medical benefits were made against both plaintiff and defendant. According to

plaintiff, both it and defendant denied the claims on the basis that other insurance was available. Plaintiff asserted that, despite the fact that it was not liable for benefits pursuant to the terms of its contracts, it paid the insureds an aggregate of $ 11,177.15 in benefits and demanded reimbursement from defendant, but defendant refused such. Plaintiff requested that the trial court enter a declaratory judgment that defendant was responsible for payment in the amount noted above.

Defendant answered the complaint, contending that under its insurance contract it was not responsible for the payment of benefits when there was applicable primary auto insurance coverage, such as plaintiff's, available at the time of the claim.

Defendant moved for summary judgment pursuant to GCR 1963, 117.2(1) [now MCR 2.116(C)(8)], but argued its motion under both 117.2(1) and 117.2(3). The trial court determined that neither party was entitled to a judgment that the other party was solely responsible for the payment of benefits. Rather, the trial court determined that, because both contract provisions were unambiguous, the only proper remedy would be to hold each party responsible for the payment of one-half the benefits owed to the insureds. An order of summary judgment to this effect was entered on June 25, 1984. At issue is the apportionment of liability between the two insurers.

Defendant asserts that its policy was a medical insurance policy with a coordination-of-benefits provision which specifically stated that if the insured had no-fault auto insurance, the auto insurance carrier would be liable for no-fault benefits. Since the insureds in the instant case had no-fault insurance, defendant reasons that, under the clear language of its policy, plaintiff is primarily responsible for the payment of no-fault benefits.

Plaintiff, on the other hand, contends that, since no-fault insurance is compulsory and the health insurance provided by defendant is not, the coordination-of-benefits clauses in its policies should take precedence over and supersede the coordination-of-benefits clause in defendant's policy.

Section 3109a of the no-fault act, MCL 500.3109a; MSA 24.13109 (1), requires insurers providing personal protection insurance to offer coordination-of-benefits options to their insureds, at correspondingly reduced rates, which "coordinate" recovery under multiple policies and seek to obviate the potential for double recovery, thereby serving to reduce insurance costs.

In *Nyquist* v *Aetna Ins Co*, 84 Mich App 589; 269 NW2d 687 (1978), *aff'd* 404 Mich 817; 280 NW2d 792 (1979), this Court held that an insured could coordinate his no-fault insurance benefits with Blue Cross & Blue Shield benefits. Further, in *LeBlanc* v *State Farm Mutual Automobile Ins Co*, 410 Mich 173; 301 NW2d 775 (1981), the Supreme Court held that an insured could also elect to coordinate his no-fault benefits with benefits provided under the Medicare program. Some confusion reigns, however, where the insurance policies at issue both contain coordination-of-benefits clauses.

In *Farm Bureau Mutual Ins Co* v *Horace Mann Ins Co*, 131 Mich App 98; 345 NW2d 655 (1983), *lv den* 419 Mich 880 (1984), this Court held that it is absurd to assume "that where conflicting 'other insurance' provisions exist by reason of overlapping coverages of the same occurrence[,] the provisions of one policy must yield to the provisions of the other". 131 Mich App 103, quoting from *Lamb-Weston Inc* v *Oregon Automobile Ins Co*, 219 Or 110, 128; 341 P2d 110, 118-119 (1959). This Court ruled that the conflicting clauses were to be declared repugnant and were to be rejected *in toto*. 131 Mich App 103-104. Once

the conflicting clauses were disregarded, this Court found that both policies would clearly provide coverage and each insurer's liability would then be prorated based on the proportion of the combined policy limits represented by the limits of each insurer's policy. *Farm Bureau*, however, did not involve no-fault insurance.

In *Mary Free Bed Hospital & Rehabilitation Center* v *Ins Co of North America*, 131 Mich App 105; 345 NW2d 658 (1983), *lv den* 419 Mich 943 (1984), this Court relied upon *Farm Bureau, supra*, in reaching the same result. *Mary Free Bed* also did not involve no-fault insurance.

In *United States Fidelity & Guaranty Co* v *Group Health Plan of Southeast Michigan*, 131 Mich App 268; 345 NW2d 683 (1983), this Court again addressed the question of how conflicts between coordination-of-benefits clauses should be resolved. There, a no-fault insurance policy and the provisions of a group subscriber contract with a health maintenance organization were at issue. However, this Court found that there was no true conflict between the clauses because the plaintiff no-fault insurer's "excess clause" clearly indicated that benefits were not available if there was other insurance. On the other hand, the Court ruled that the defendant's "excess clause" only provided that its benefits "may be reduced" if other insurance was available. In addition, defendant's policy was unclear as to whether the claimant must merely qualify for or actually receive other benefits for the coordination-of-benefits provision to operate. Because of the clarity of plaintiff's excess clause, coupled with the ambiguity contained in defendant's, this Court concluded that the defendant should be held primarily liable. No reliance was placed on *Farm Bureau, supra*, or *Mary Free Bed, supra*.

In *Federal Kemper Ins Co, Inc* v *Health Ins Administration, Inc*, 135 Mich App 76; 351 NW2d 900 (1984), plain-

tiff was the claimant's no-fault insurance carrier at the time of the injury. The defendant provided the claimant with health insurance under a group policy. Plaintiff paid the claimant's medical bills arising out of an automobile accident, but defendant refused to reimburse it for those payments. Both the plaintiff and the defendant claimed that it was a secondary insurer relative to the other. The plaintiff's insurance contract provided that it would not pay benefits to the extent that benefits were paid or payable for allowable expenses under the provisions of any other insurance. On the basis of this Court's ruling in *Farm Bureau, supra*, the *Kemper* Court ruled that both the plaintiff and the defendant were liable for benefits to the claimant, prorated as to the proportion of the combined policy limits represented by the limits of each insurer's policy.

While the above-cited cases have reached reasonable results, we choose not to follow them here inasmuch as the legislative history surrounding the enactment of § 3109a does not appear to have been relied upon or addressed in those cases. In their briefs, the instant parties essentially argued various policy considerations in support of their respective positions, neither party seeking the result obtained in *Farm Bureau, supra*, and *Kemper, supra*, which prorated liability based on policy limits. At oral argument, however, plaintiff cited this Court's decision in *Dean* v *Auto Club Ins Ass'n*, 139 Mich App 266; 362 NW2d 247 (1984), which extensively discussed the legislative history of § 3109a. In reviewing this history as discussed in *Dean, supra*, and in *LeBlanc* v *State Farm, supra*, and *Nyquist* v *Aetna, supra*, we conclude that it evinces a clear legislative intent that the no-fault insurer provide only secondary coverage under § 3109a.

1974 House Bill 5724 was enacted into 1974 PA 72, the present MCL 500.3109a; MSA 24.13109(1). The analysis of

HB 5724 prepared by the House Insurance Committee set forth several arguments in support of, and in opposition to, the bill. Each argument, however, proceeded from the premise that the coordination of benefits envisioned by the bill would make health and accident insurance, including that provided by Blue Cross & Blue Shield of Michigan, the primary coverage. The following concerns were expressed (and positions taken) in the analysis with respect to § 3109a:

"*Background Information:*

"Currently 4 of the 283 auto insurance companies doing business in Michigan offer deductibles or exclusions which cover only those items not covered by the policy holder's health and accident insurance. (These 4 auto-insurers *offer the secondary or 'wrap-around' coverage.*)

"Last September, Blue Cross/Blue Shield filed modifications with the Insurance Bureau proposing to allow its members to coordinate their medical benefits with their auto coverage by making the no-fault coverage primary and the Blues coverage wrap-around or the secondary coverage.

"*Argument For:*

"The bill would save millions of dollars for Michigan drivers and would offer them an opportunity to eliminate their duplicate, overlapping insurance coverage *since automobile insurers would be required to offer deductibles or exclusions which wrap-around a policy holder's health and accident coverage.* No-fault insurers would offer these deductions at reduced premiums, and State insurance officials estimate the 5 to 6 million Michigan drivers could save $100 million annually.

"*Argument For*:

"Passage of the bill would create more flexibility in health and accident coverage by offering consumers an insurance option which the vast majority of underwriters operating in Michigan do not offer. Further, if the Blue Cross/Blue Shield plans gain approval for their proposed modifications, the consumer seeking health and accident coverage will have yet another option from which to choose. The bill does not make it mandatory for an insurance buyer to select these deductibles and exclusions so many could still opt for overlapping coverage.

"*Argument For*:

"*The skyrocketing hospital and medical costs could be contained to a greater extent with health and accident as the primary coverage* since these policies, like the Blue Cross/Blue Shield plans, have established limits on their reimbursement of doctor and hospital expenses. A physician who knows his or her patient has unlimited medical coverage has no incentive to keep the doctor bill at a minimum.

"*Argument Against*:

"The efficiency and ease with which the no-fault statutes have been applied would be hampered by the bill, and insurance premiums could actually rise rather than decline. In lieu of automatic, fully comprehensive coverage by the auto insurer (under no-fault), *under the proposed wrap-around deductibles*, both the no-fault insurer and the health and accident company would be required to devote extra time and money to investigate an accident claim. They would have to reach an agreement to the extent to which

each is responsible to the injured person. The rapid simplified reparations which have thus far characterized no-fault settlements would be bogged down by this process of double investigation and adjustment.

"*Argument Against*:

"No-fault insurers would be unable to establish fair and equitable rates since *the multitude of wrap-around combinations would make it impossible to determine a schedule for the proposed deductibles and exclusions*. No-fault is only 4 months old and insurance companies have yet to accumulate enough data to establish those premiums confidently. Spokesmen for the industry claim 18 months of data are necessary for the establishment of accurate premiums for a specific no-fault policy.

"*Argument Against*:

"*Required secondary coverage by no-fault providers* raises many ambiguities concerning the insurance statutes since no-fault is, by law, a mandatory requirement. Persons who reduce their no-fault medical coverage and then change jobs, or become unemployed, or those who misrepresent their accident and health coverage could be left without the minimum coverage required by the no-fault statutes.

"*Argument Against*:

"*Primary coverage by health and accident insurers would weaken the coverage on many persons* and would serve to confuse policyholders since it would substitute unknown, variable, noncompulsory benefits for compulsory, definitive and standardized benefits. No-fault is specifically designed to cover automobile accidents and

injuries, offering the same basic coverage for everyone, but the accident and health insurers as well as Blue Cross/Blue Shield provide a puzzling number of alternative coverages, none of which are [*sic*] as complete and comprehensive as those of no-fault.

"*Argument Against*:

"*The bill discriminates against auto personal injury protection (no-fault) insurers since it does not require the accident and health insurers or Blue Cross/Blue Shield plans to offer similar deductibles to persons desiring to make their comprehensive no-fault policies primary, with other coverages being secondary.* If the intent of the bill is to save money for the consumer by offering a maximum of alternatives at reduced premiums, then health carriers should also be compelled to offer wrap-around coverage. *If accident and health coverage were made secondary, the reduction in premiums would be much larger*, particularly for persons whose policies include coverage for many dependents.

"*Neutral Discussion (Proposed Amendments)*:

"The Michigan Association of Insurance Companies suggests offering consumers another alternative by requiring health and accident insurers (by statute) to offer at reduced rates, deductibles and exclusions to persons already covered under no-fault." (Emphasis added.)

As is manifest from the legislative analysis, § 3109a was intended to offer an option to no-fault consumers to allow them to make their no-fault coverage *secondary*. We find this conclusion inescapable from the concerns expressed.

Furthermore, a letter to Governor William G. Milliken from Daniel J. Demlow, the Commissioner of Insurance, dated February 26, 1974, also evinces a similar understanding as to HB 5724. Therein the commissioner noted that the "bill gives each consumer the chance to select or reject deductibles *based on his existing non-automotive health and accident coverage*". (Emphasis added.)[1] This statement makes sense only if health and accident insurance is considered primary.

Additionally, the Supreme Court in *LeBlanc*, *supra*, pp 202-203, had the following to say concerning the above analysis of HB 5724:

> "The analysis of HB 5724 prepared by the House Insurance Committee indicates that *the bill would eliminate duplicate coverage by making private accident and health insurance, as well as the group plans of Blue Cross and Blue Shield, primary sources of reimbursement for accident-related medical and hospital expense.*" (Emphasis added.)

As further support for this conclusion, we look to the general purpose of § 3109a. It has been stated that § 3109a was designed to "contain or reduce insurance costs", *LeBlanc*, *supra*, p 197, and "was * * * concerned with the rising cost of health care". *Dean*, *supra*, p 273. These two objectives are best fulfilled where health and accident insurance is primary, since, as noted in the analysis, "these policies, like Blue Cross/Blue Shield plans, have established limits on their reimbursement of doctor and hospital expenses". By contrast, expenses paid by no-fault insurance are subject to no such limits. To effectuate the intent of the Legislature in containing

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[1] **See *LeBlanc* v *State Farm*, *supra*, pp 194-195, for further excerpts of this letter.**

insurance costs in general, and health care costs in particular, health and accident insurance must be deemed primary.

In the instant case, we are unaware of the complete nature of defendant's policy. The lower court record contains only an excerpt of the page of defendant's policy on which the coordination-of-benefits clause is placed.[2] Defendant advances no statutory support for its attempt to make no-fault coverage primary,[3] nor is there evidence on the record that the approval of the Insurance Commissioner has been requested or granted

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2 Defendant's coordination-of-benefits clause provides:

> "Section 23
>
> "Co-ordination of Benefits
>
> "In addition to the benefits payable under this plan, sometimes an employee or dependent is entitled to benefits for the same hospital or medical expenses under group fault or no-fault auto insurance, individual no-fault auto insurance, medicare or another group plan. Should this type of duplication occur, the benefits under this plan will be co-ordinated so that the total benefits from all plans will not exceed the hospital or medical expenses actually incurred. *In all cases employees with no-fault auto insurance coverage, the auto insurance carrier will be primary.*"

3 We note parenthetically that 1984 PA 64, MCL 550.251 *et seq.*; MSA 24.13671 *et seq.*, the Coordination of Benefits Act, in conjunction with 1984 PA 65 through 70, addresses the problem of overlapping benefits (and the coordination thereof) *among group health policies*. These acts provided for a standardized order of benefit determination among such group health policies in the areas of group disability (Act 65, MCL 500.3609a *et seq.*; MSA 24.13609[1] *et seq.*), group policies of a health care corporation (Act 66, MCL 550.1401 *et seq.*; MSA 24.660 [401] *et seq.*), group policies of a medical care corporation (Act 67, MCL 550.313b: MSA 24.603[2]), group policies of a hospital service corporation (Act 68, MCL 550.510b; MSA 24.630[2]), the policies of health maintenance organizations (Act 69, MCL 333.21074; MSA 14.15 [21074]), and of dental care corporations (Act 70, MCL 550.369a; MSA 24.650 [19a]). Section 2(i) of 1984 PA 64, however, defines "policy" in such a way (i.e., "a group disability insurance policy",) that no-fault insurance is not included. The analysis performed on 1984 Senate Bill 363 (enacted into 1984 PA 64) by the Senate Commerce Committee is also silent as to no-fault insurance.

with respect to this clause.[4] There is further no evidence that defendant's coordination-of-benefits clause was offered in such a way as to foster consumer savings, a major goal of § 3109a, see analysis on HB 5724, *supra*, or as to how premiums or employee co-pay were affected by this clause to insure that defendant is not reaping unearned premiums. That is, because no-fault is mandatory and coordination of benefits must be offered *at a reduced rate*, the insured gains an advantage from such a clause by the required reduction in premium while the insurer's reduced profits reflect a corresponding reduction in its potential liability. No such check necessarily applies to health and accident insurance. It would not be difficult to simple insert a coordination-of-benefits clause in a health and accident policy without a corresponding reduction in premium or co-pay where the determination of primary liability is governed by the policy language.

In an area such as no-fault insurance and, for that matter, health insurance as well, where the regulatory scheme established by the Legislature is of such a pervasive nature, we agree with plaintiff that the clarity of

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4 See *Siller* v *Employers Ins of Wausau*, 123 Mich App 140, 142; 333 NW2d 197 (1983). It is also noteworthy that MCL 500.3438, 500.3440; MSA 24.13438, 24.13440, which provide for the coordination of benefits in certain insurance contracts, similarly do not apply to no-fault insurance by virtue of MCL 500.3400(4); MSA 24.13400(4) and MCL 500.3600(1); MSA 24.13600(1). In view of the pervasiveness of the regulatory scheme existing with respect to coordination of benefits as contained in these sections, as well as those sections discussed in note 3, *supra*, in concert with the legislative history pertaining to 1974 PA 72, we believe that the new legislation's failure to coordinate such group health insurance with no-fault (and the similar failure of MCL 500.3438, 500.3440; MSA 24.13438, 24.13440) serves to indicate that no-fault coverage may not be made primary, *i.e.*, it is to be coordinated solely under the direction of § 3109a of the no-fault act.

policy language should not govern apportionment of liability.[5]

Reversed and remanded for entry of judgment and determination of liability consistent with this opinion. No costs, a question of public significance being involved.

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5 The result reached in this case is not necessarily in conflict with existing case law. As noted earlier, *Farm Bureau* v *Horace Mann*, *supra*, and *Mary Free Bed* v *INA*, *supra*, did not deal with no-fault insurance. *US Fidelity* v *GHP*, *supra*, while dealing with no-fault, did not involve conflicting clauses. And, although *Kemper* v *health Ins*, *supra*, appears to be inconsistent, there is no indication that the parties raised the issue of legislative intent. Both parties ostensibly argued the respective provisions in the insurance policies. In the case *sub judice*, however, plaintiff touched upon the relevant policy considerations in its brief and, at oral argument, specifically raised the intent of the Legislature as discussed in *Dean* v *Auto Club*, *supra*.

ORDER OF SUMMARY JUDGMENT

(State of Michigan — Circuit Court — County of Oakland)

(Filed June 25, 1984)

(AUTO CLUB INSURANCE ASSOCIATION, f/k/a/ D.A.I.I.E., Subrogee of Ali Chehab; Faysal Mazlous; Houhad Jamil Bazzi; Hussein H. Habab; Nasri Jomaa; Ali K. Hashem; and Sami M. Alaouie, et al, Plaintiffs, -vs- FREDERICK AND HERRUD, INC., a corporation, Defendant — No. 82-246269 CK; Hon. FREDERICK ZIEM)

At a session of the Court held in the City of Pontiac, County of Oakland, and State of Michigan on JUNE 25, 1984.

PRESENT: HON. [*Frederick C. Ziem*],
CIRCUIT COURT JUDGE.

IT IS HEREBY ORDERED that the Motion for Summary Judgment submitted to this Court for consideration by the Plaintiff and by the Defendant are decided as follows:

The parties in this action are found to be in equal priority to pay the benefits of their respective insureds.

WHEREFORE the Defendant is ordered to reimburse to the Plaintiff 50% of all monies paid as benefits to the insureds involved in this action.

/s/ FREDERICK C. ZIEM
CIRCUIT COURT JUDGE

Prepared by:
/s/ JOHN WESLEY KLINE, Attorney for Plaintiff
Approved by:
/s/ JAMES M. RIFKIN, Attorney for Defendant

(*Certification Omitted*)

ORDER

(State of Michigan — Supreme Court)

(Entered November 2, 1992)

Michael F. Cavanagh, Chief Justice;
Charles L. Levin, James H. Brickley, Patricia J. Boyle, Dorothy Comstock Riley, Robert P. Griffin, Conrad L. Mallett, Jr., Associate Justices.

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff-Appellant, v PENTWATER WIRE PRODUCTS, INC., Self-Funded Employee Health Benefit Plan, Defendant-Appellee — SC: 93925; CoA: 126174; LC: 86-2900-CK)

On order of the Court, the delayed application for leave to appeal is considered, and it is GRANTED.

We further ORDER that this case be argued and submitted to the Court together with the case of *Auto Club Insurance Association* v *Frederick & Herrud, Inc* (Docket No. 93816), at such future session of the Court as both cases are ready for submission.

(Certification Omitted)

OPINION

(State of Michigan — Court of Appeals)

(Filed January 6, 1992)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff-Appellee, v PENTWATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant-Appellant — No. 126174)

Before: Danhof, C.J., and Doctoroff and Brennan, JJ.

PER CURIAM.

Alice Guetzka, whose husband was employed by Pentwater Wire Products, Inc., was seriously injured in an automobile accident. Pentwater provides health benefits for its employees and their dependents through a self-funded health and accident benefit plan. Plaintiff, Guetzka's no-fault insurance carrier, paid the medical expenses incurred as a result of the accident. Plaintiff thereafter sought reimbursement from defendant. Defendant denied the claim and this action was filed. The trial court granted plaintiff's motion for summary disposition. Defendant appeals as of right from the order granting summary disposition to plaintiff and from the denial of its motion for new trial and relief from judgment. We find defendant's claim that § 3109a of the no-fault act, MCL 500.3109a; MSA 24.13109(1), is preempted by the Employee Retirement Insurance Security Act ("ERISA"), 29 USC 1001 *et seq.*, dispositive and reverse.

This case is controlled by *Auto Club Ins Ass'n* v *Frederick & Herrud, Inc*, ___ Mich App ___; ___ NW2d ___ (Docket No. 135974, rel'd 10/8/91), which held that state regulation of self-funded employee benefit plans is preempted by ERISA. Therefore, § 3109a is preempted by ERISA. The Court also rejected the argument that the

purchase of stop-loss insurance transforms a benefit plan into an insured plan for purposes of ERISA. Applying the Court's ruling to this case, we hold that plaintiff's claim is barred.

Plaintiff's argument that its claim survives application of ERISA preemption is not properly raised on appeal because plaintiff did not file a cross-appeal. MCR 7.207; *Bhama* v *Bhama*, 169 Mich App 73, 83; 425 NW2d 733 (1988). In any event, we would reject plaintiff's argument.

Reversed and remanded to the circuit court for entry of an order granting summary disposition in favor of defendant. We do not retain jurisdiction.

/s/ Robert J. Danhof
/s/ Martin M. Doctoroff
/s/ Thomas J. Brennan

ORDER

(State of Michigan — Court of Appeals)

(Dated January 10, 1991)

(Auto Club Ins v Pentwater Wire Products, Inc. — Docket #126174; L.C. #86-02900-CK)

Janet T. Neff, Presiding Judge;
Donald E. Holbrook, Jr., Elizabeth A. Weaver, Judges

The Court orders that the motion for peremptory reversal pursuant to MCR 7.211(C)(4) is DENIED for failure to persuade the Court of the existence of manifestly reversible error warranting peremptory relief without argument or formal submission.

/s/ Janet T. Neff
Presiding Judge

A true copy entered and certified by Norbert G. Jaworski, Chief Clerk, on January 10, 1991.

(SEAL)

/s/ Norbert G. Jaworski
Chief Clerk

ORDER DENYING DEFENDANT'S MOTION FOR NEW TRIAL OR FOR RELIEF FROM JUDGMENT

(State of Michigan — Circuit Court — County of Oceana)

(Dated January 29, 1990)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, -vs- PENT-WATER WIRE PRODUCTS, INC., SELF-FUNDED EMPLOYEE HEALTH BENEFIT FUND, Defendant — NO: 86-2900-CK; JUDGE TERRENCE R. THOMAS)

At a session of said Court held in the City of Hart, County of Oceana, State of Michigan, on January 29, 1990.

PRESENT: [*Terrence R. Thomas*],
CIRCUIT COURT JUDGE.

In accordance with the Court's written Opinion of January 3, 1990;

IT IS HEREBY ORDERED that Defendant's Motion for New Trial and for Relief from Judgment is denied.

/s/ HONORABLE TERRENCE R. THOMAS
Circuit Court Judge

AMENDED JUDGMENT

(State of Michigan — Circuit Court — County of Oceana)

(Dated November 20, 1989)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, -vs- PENTWATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant — NO: 86-2900-CK; JUDGE TERRENCE R. THOMAS).

At a session of said Court held in the City of Hart, County of Oceana, State of Michigan, on November 20, 1989.

PRESENT: [*Terrence R. Thomas*],
CIRCUIT COURT JUDGE.

IT IS HEREBY ORDERED AND ADJUDGED that Plaintiff AUTO CLUB INSURANCE ASSOCIATION (ACIA) have and recover from the Defendant, PENTWATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, the amount of FIVE HUNDRED ELEVEN THOUSAND, TWO HUNDRED FIFTY-THREE and 08/100 ($511,253.08) DOLLARS, calculated as follows:

$340,899.40 – Benefits

14,165.00 – Interest from date of payment until filing of Complaint

155,188.68 – Prejudgment interest from June 16, 1985 through November 20, 1989

$510,253.08 – TOTAL

$ 1,000.00 – Attorney Fees

$511,253.08 – GRAND TOTAL

/s/ HONORABLE TERRENCE R. THOMAS
Circuit Court Judge

OPINION ON DEFENDANT'S MOTION FOR A NEW TRIAL OR FOR RELIEF FROM JUDGMENT

(State of Michigan — Circuit Court — County of Oceana)

(Dated January 3, 1990)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, -vs- PENT-WATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant — File #86-2900-CK)

Defendant moves for a new trial pursuant to MCR 2.611 and for relief from judgment pursuant to MCR 2.611 on the basis of recent developments of decisional law. The court denies the defendant's motions.

Alice Guertzka was injured in an automobile accident on June 9, 1985. At the time of the accident, she was eligible for health benefits from the defendant. She was also insured by the plaintiff under a No-Fault automobile insurance policy which contained a Coordinated Medical Benefits provision. Consistent with its policy, plaintiff has paid out more than $500,000.00 in medical benefits and seeks recovery of the same from the defendant pursuant to the general rule of *Federal Kemper Insurance* v *Health Insurance Administration, Inc*, 424 Mich 537, 383 NW2d 590 (1986): When both policies contain coordination of benefits clauses which seek to make each policy excess over the other, the health insurance policy is primary. After determining on summary disposition motion that plaintiff's insured was not "legally separated" as defined by the defendant's health insurance plan and therefore not precluded from coverage, a judgment was entered in favor of the plaintiff in the amount of $534,617.00 plus $1,000.00 in attorney's fees.

The defendant now argues in it present motion that the case of *Liberty Mutual Ins Group* v *Iron Workers*

Health Fund of Eastern Michigan, 879 F2d 1384 (6th Cir 1989), determined that § 3109a of the Michigan No-Fault Insurance Act as applied to ERISA health plans is now preempted by federal law and therefore it is not liable for the medical expenses paid by the plaintiff.

Plaintiff responds that *Liberty* is inapplicable factually for the reason that the Iron Workers' Plan did not provide for any benefits arising out of an automobile accident whereas defendant's health insurance plan provides for coordination of benefits arising out of auto accidents as opposed to no insurance.

The court agrees with the plaintiff and would direct the defendant to pages 97-102 of the course handbook entitled "NO FAULT UPDATE 1989" cosponsored by the Negligence Law Section of the State Bar of Michigan and The Institute of Continuing Legal Education, Ann Arbor, Michigan. By reading this handbook, the defendant may gain an insight into the problem of § 3109a: Coordinated Benefits which this court believes the defendant now lacks. The court has attached a copy of the appropriate section to this opinion for defendant's edification.

/s/ Terrence R. Thomas
Circuit Judge

Dated: January 3, 1990

* * *

II.

SECTION 3109a: COORDINATED BENEFITS

A. *Introduction*

(1) The statute provides:

> "An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles

and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household."

(2) Statutory purpose

– Same purposes as § 3109(1): contain cost of auto insurance and avoid duplicative recovery; also, lets insured voluntarily reduce costs and tailor coverages.

B. *Competing Coordination Provisions Clauses in No-Fault and Health Insurance Policies*

(1) *General Rule:* When both policies contain coordination of benefits clauses which seek to make each policy excess over the other, the health insurance policy is primary. *Federal Kemper Insurance* v *Health Insurance Administration, Inc.*, 424 Mich 537 (1986). *Rationale*: The Legislature's intent in enacting Section 3109a was to permit insureds in Michigan the option of coordinating their medical benefits; a contrary result would have effectively precluded that right.

The Court in *Federal Kemper* identified three types of coordinated benefits provisions:

Excess
Pro rata
Escape or other insurance

In all three instances, health insurance benefits *are available*, but coordinated with the other coverage.

This general rule was adopted by the Courts in other cases both before and after *Federal Kemper*.

– *Excess Clause*. Health carrier is primary despite stating in its policy that. "In all cases employees with no-fault auto insurance coverage, the auto insurance carrier will be primary". *Rationale*: Insureds must be given option to make No-Fault secondary; Legislature wants to hold down cost of No-Fault insurance. *Auto Club Insurance Association* v *Frederick and Herrud, Inc.*, 145 Mich App 722 (1985). Reasoning followed in *Transamerica Insurance* v *American Republic Insurance*, 149 Mich App 167 (1985).

– *Escape Clause*. Health carrier utilized "escape clause" (no obligation to pay after it pays first $300 of auto-accident related medical bills). Court of Appeals, following *Federal Kemper*, concluded this was another type of "other insurance" clause. Health carrier found primary. *Michigan Mutual Insurance Company* v *American Community Mutual Insurance Company*, 165 Mich App 269 (1987), *lv den*, 430 Mich 884 (1988). Accord: *Transamerica Insurance* v *American Community Mutual Insurance*, 175 Mich App 377 (1989).

– *Purported Exclusion Clause*: Health carrier's policy included an *exclusion* for charges for which the employee was entitled to No-Fault benefits. The Court of Appeals followed *Federal Kemper* and found the health carrier primary. *Auto-Owners Insurance Company* v *Lacks Industries*, 156 Mich App 837 (1986), *lv den*, 428 Mich 902 (1987). *Note*: The health policy did not exclude all benefits arising out of a motor vehicle accident, but only did so *if* the insured was entitled to No-Fault benefits; therefore, this was really a coordination of benefits provision.

– See also *Auto-Owners Insurance Company* v *State Farm Mutual Insurance Company*, U.S. District Court for Western District of Michigan, January 8, 1989, where Judge Hillman also rejected health insurer's argument that No-Fault carrier should have inspected the health insurance policy which insured procured first.

C. *Exception to Federal Kemper Where Health Carrier Excludes All Coverage for Automobile Accident Related Benefits Regardless of Existence of Other Coverage*

– Three Federal District Court rulings have enabled health insurers to avoid all liability for accident-related automobile medical expenses *if* their health plan absolutely *excludes any and all coverage* for these expenses *without reference to the availability of other insurance. Transamerica Insurance Company of North America* v *Iron Workers Local 340 Health Care Fund*, U.S. District Court, Western District of Michigan, File No. G88-98 CA1 (August 8, 1988); *Transamerica Insurance Company of North America* v *Peerless Industries (MASCO), et al*, U.S. District Court, Western District of Michigan, File No. G87-857-CA1 (November 2, 1988); *Nationwide Insurance Company* v *J.T. Batts, Inc.*, U.S. District Court, Western District of Michigan, File No. [illegible]8-557 (January 19, 1989).

– Provision in *Iron Workers Local 340 Health Care Fund*, states that the Fund:

> "... does not provide benefits for charges incurred in connection with ... (6) any accidental bodily injury which arises out of an automobile accident, *whether or not* the eligible member ... is entitled to benefits under No-Fault laws or similar legislation.["]

The language in one of the defendant's plans in *Peerless Industries*, read as follows:

"Michigan No-Fault Exclusion Benefits are not payable under this Plan for injuries received in an accident involving a car or other motor vehicle."

In both instances the Courts concluded that these provisions were not escape clauses (one type of coordinated benefits provision) and, therefore, *Federal Kemper* was not controlling. These provisions excluded coverage *without regard to the existence of other coverage*; therefore, they were absolute exclusions. The Courts reasoned that the health plans were under no statutory duty to offer coverage for medical expenses arising from motor vehicle accidents. *Note*: One or more of these cases will end up in the Sixth Circuit Court of Appeals.

PRACTICE SUGGESTION: Counsel should obtain the insured's health plan documents to determine whether the plan coordinates with No-Fault (health insurer primary) or completely excludes auto accident coverage (No-Fault *probably* primary).

D. *Recent Cases as to What Constitutes "Other Health and Accident Coverage"*

(1) *HMO*. Payments made to an insured by an HMO *do constitute* "other health and accident coverage". *United States Fidelity and Guaranty Company* v *Group Health Plan of Southeast Michigan*, 131 Mich App 268; 345 NW2d 683 (1983); Accord: *Health Care* v *Transamerica*, 167 Mich App 218 (1988) when the Court applied *Federal Kemper* and made the HMO primary.

(2) *Federal Military Medical Benefits*. These benefits, which are paid pursuant to federal statute, do constitute "other health and accident coverage"

within Section 3109a. *Tatum* v *GEICO*, 431 Mich 663 (1988).

(3) *Medicare Supplement Policy*. In *Employers Mutual Insurance Company* v *American Community Mutual Insurance Company*, 175 Mich App 643 (1989) the plaintiff was covered under a coordinated No-Fault policy and also under a Medicare supplemental policy. In granting the No-Fault carrier the right to set off the Medicare supplemental payments, the Court reasoned:

(a) This case involved a conflicting coordination of benefits provision; *Federal Kemper* makes other health coverage primary.

(b) Medicare constitutes "other health and accident coverage" under § 3109a citing *LeBlanc* and *Lewis*.

The Court refused to alter its position even in light of recent federal legislation indicating that Medicare should be secondary. It interpreted the federal statute to shift primary responsibility to the No-Fault carrier only when that carrier could reasonably be expected to pay.[2] As *Federal Kemper* provides that the auto insurer is secondary in such situations, No-Fault can't be "expected to" pay these benefits. *Note*: The Court specifically *disagreed* with defendant's argument that the federal statute made Medicare secondary.

(4) *A Full Benefits No-Fault Policy in The Same Order of Priority*. The claimant, Justine Bravata, was

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[2] **42 USCA § 1395y(b)(1) states in pertinent part: "Payment under this subchapter may not be made with respect to any item or service to the extent that payment has been made, *or can reasonably be expected to be made* promptly . . . under no fault insurance."**

insured under two No-Fault policies. Auto-Owners issued a full benefits policy to Ms. Bravata's estranged husband; Farm Bureau issued a coordinated benefits policy to the claimant's father. Both insurers were in the same order of priority and, therefore, were bound to equitably distribute the loss under Section 3115(2). The Court of Appeals held that the full benefits policy *did constitute* "other health and accident coverage" and, therefore, Auto-Owners had to pay all the No-Fault benefits. *Auto-Owners* v *Farm Bureau*, 171 Mich App 46 (1987); Accord: *Department of Social Services* v *American Commercial Liability Insurance Company*, ___ Mich App ___ (1989).

E. *ERISA Preemption*

Many employee medical benefit plans are regulated by a federal statute: the Employee Retirement Income Security Act (ERISA). The question has arisen whether ERISA's provision (which would make No-Fault primary) should govern over Section 3109a (which provides the health insurer is primary).

That dispute now seems to be settled: ERISA should never preempt the No-Fault insurer's right to coordinate under Section 3109a, i.e., employee medical benefits plans will be primary.

(1) *Insured ERISA Plans.* If the ERISA health plan is *commercially insured* (i.e., the ERISA insurer purchases insurance including stop-loss insurance), then the Courts agree that the plan is subject to state insurance law. Therefore, Section 3109a is enforced per *Federal Kemper* and *the health plan* is primary. See *Frankenmuth Mutual Insurance Company* v *Meijer, Inc.*, ___ Mich App ___ (June 20, 1989)

for application of this rule to an employee benefit plan with stop-loss coverage.

(2) *Uninsured ERISA Plans*. Technically, a conflict exists. However, the two cases cited for the proposition that the No-Fault carrier is primary are pre-*Northern Group Services*. Since *Northern Group* state courts have ruled in conformity with NGS.

(a) No-Fault carrier found to be primary (i.e., ERISA preemption permitted).

– Two Court of Appeals panels have so concluded, for different reasons.

– The *State Farm* v *C.A. Muer Corp.*, 154 Mich App 330 (1986) case involved a dispute between an uninsured employee medical benefit plan and a coordinated No-Fault plan. The Court reasoned that since the plan was not insured by commercial insurance, it was not subject to the insurance laws of Michigan. Under ERISA, the plan is not an insurance company and may not be "deemed" an insurance company.

– In *Udell* v *Georgie Boy Manufacturing*, 174 Mich App 171 (1988) the Court concluded that the "deemer provision" precluded the State of Michigan from labeling the plan as an insurance company so as to permit the state to enforce Section 3109a. *Note*: The dissent noted that the employee health plan carried stop-loss insurance; therefore, it should be subject to the state insurance code (i.e., No-Fault statute).

(b) Health plan found to be primary (i.e., ERISA not permitted to preempt Section 3109a).

– Lead case: *Northern Group Services, Inc.* v *Auto-Owners Insurance Company*, 833 F2d 85 (CA 6, 1987) cert den 106 S Ct 801 (1989). The NGS Court took a

broader look at the "deemer clause". It ruled that in determining whether ERISA should preemption state regulation depended on Congress' intent in enacting the deemer clause, federal interest in uniformity of administration of ERISA plans, the national policy favoring the state's right to regulate insurance, and the state Legislature's intent in enacting Section 3109a. It concluded that there was not a sufficient interest in ERISA uniformity to outweigh the state's interest in regulation of insurance.

– *Michigan Millers Mutual Insurance Company* v *West Michigan Health Care Network*, 174 Mich App 196 (1988), *Auto Club Insurance Association* v *Frederick and Herrud*, Court of Appeals File No. 96693, March 6, 1989, and *Cadillac Insurance Company* v *American Community, et al*, (U.S. District Court for Eastern District of Michigan, File No. 88-CV 73808, April 5, 1989) adopt NGS reasoning.

F. *What if a Government Benefit Also Qualifies as "Other Health and Accident Coverage"?*

The Michigan Courts have noted that in some unique situations a government benefit [mandatorily set off under § 3109(1)] may also qualify as "other health and accident coverage" under Section 3109a.

The situation first arose in *LeBlanc* v *State Farm Mutual Automobile Insurance Company*, 410 Mich 173; 301 NW2d 775 (1981). There, the Court concluded that while Medicare was a government benefit, it also constituted "other health and accident coverage". The Supreme Court ruled that, as the benefits met the "other health and accident" criteria, they were coordinating *at the option of the insured.* Therefore, Medicare may only be set off if the insured has elected coordinated benefits (i.e., the

insured with a full benefits policy may "double dip"). *Note*: This result may have been changed by subsequent federal legislation.

Similarly, in *Tatum*, the plaintiff's federal military medical benefits met both criteria. As these benefits were "other health and accident coverage", *the insurer had a duty to offer a coordinated policy under Section 3109a*. It did not do so. Therefore, it was precluded from using the Section 3109(1) exclusion. *Note:* Federal military medical benefits may be coordinated if the insured has opted for a coordinated benefits policy.

OPINION ON PLAINTIFF'S AND DEFENDANT'S MOTIONS FOR PARTIAL SUMMARY DISPOSITION

(State of Michigan — Circuit Court — County of Oceana)

(Dated March 27, 1989)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, vs. PENT-WATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant — File No. 86-2900-CK)

This case was originally filed in this Court on June 16, 1986, removed to the Federal District Court by the Defendant and remanded from that Court to this Court for further proceedings by order dated December 21, 1988. Prior to remand, both parties filed motions for partial summary judgment in the Federal Court which were undecided by that Court. The parties here agree that this Court should decide those motions based on the Federal pleadings.

The issue presented by both motions, apparently one of first impression in Michigan, is whether the filing of a formal complaint for divorce and the issuance of temporary orders consistent therewith constitutes as "legal separation" as defined by the Defendant's Plan of health insurance.

At the time relevant to this suit, the Plan provided health insurance benefits to employees and their dependents. Section 4.3-11 of the Plan, in the part that relates to spouses defined "dependent" as follows:

> "(i) the wife or husband of an employee, while not divorced or legally separated from the employee;["]

The plan offers no other definition or explanation as to what constitutes "legally separated." Obviously, once a spouse is no longer a dependent within the meaning of

the Plan, he or she is no longer eligible to receive the health insurance benefits under the Plan.

This Court holds as a matter of Michigan law, for the reasons set forth in the Plaintiff's Brief in Support of Plaintiff's Answer to Motion for Summary Judgment and Plaintiff's Counter Motion for Partial Summary Judgment that a party is "legally separated" only upon the entry of a judgment of annulment, divorce, or separate maintenance by a court of competent jurisdiction. Since the express language of the Plan uses the word "divorce" within the context of the Plan, "legally separated" references a judgment of annulment or separate maintenance.

Under Michigan law, during the interim between the filing of the complaint for relief and the judgment, the parties may or may not be physically separated but they are not "legally separated." Until a judgment is entered, both parties remain in the same legal relationship as before the filing of the complaint for relief with the same rights, duties, and responsibilities to each other. While the action is pending, the Court has only authority to enter orders to protect the minor children and avoid irreparable injury.

Therefore, Defendant's motion for summary judgment is denied, and the Plaintiff's motion for partial summary disposition is granted.

/s/ Terrence R. Thomas,
Circuit Judge

March 27, 1989

ORDER OF REMAND

(United States District Court —
Western District of Michigan — Southern Division)

(Dated December 21, 1988)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, v. PENT-WATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant — File No. G86-685 CA; Hon. Benjamin F. Gibson)

At a session of the Court held in and for said District and Division, in the City of Grand Rapids, Michigan, this 21st day of December, 1988.

PRESENT: HON. BENJAMIN F. GIBSON,
DISTRICT JUDGE.

In accordance with the Opinion dated December 21, 1988, IT IS HEREBY ORDERED that the instant cause of action is remanded to the Circuit Court for the County of Oceana, State of Michigan for further proceedings.

IT IS SO ORDERED.

/s/ BENJAMIN F. GIBSON
U.S. DISTRICT JUDGE

OPINION

(United States District Court —
Western District of Michigan — Southern Division)

(Dated December 21, 1988)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, v. PENTWATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant — File No. G86-685CA; Hon. Benjamin F. Gibson)

INTRODUCTION

The issue in this case is whether plaintiff's action for reimbursement under Michigan law is removable to federal court where defendant claims that the action is pre-empted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* The Court holds that removal was improper and remands this action to the Circuit Court for the County of Oceana, State of Michigan.

FACTS

Alice Guetzka was injured in a motor vehicle accident. At the time of the accident, plaintiff Auto Club Insurance Association ("Auto Club") alleges that Alice Guetzka was the wife and dependent of David Guetzka, an employee of Pentwater Wire Products, Inc. Pentwater Wire Products, Inc. provides health benefits to its employees and dependents of its employees through Pentwater Wire Products, Inc. Self-Funded Employee Health Benefit Plan (the "Plan"). Alice Guetzka was likewise insured for no-fault benefits under a policy issued by Auto Club. Auto Club assumed primary liability and paid Alice Guetzka over $100,000.00 in medical benefits.

Auto Club then brought this action for reimbursement against the Plan in the Circuit Court for the County of Oceana, claiming that the Plan bore primary liability for Alice Guetzka's medical expenses. The Plan removed Auto Club's action to this Court on the basis that the claim was pre-empted by ERISA.

ANALYSIS

Michigan law requires no-fault insurance carriers to offer a coordination of benefits plan at a lower price for those individuals who have other health and accident insurance coverage. *Federal Kemper Insurance Co.* v. *Health Insurance Administration, Inc.*, 424 Mich. 537, 546 (1986) (interpreting M.C.L. § 500.3109a). The health or accident insurer bears primary liability when the insured is also covered by a no-fault policy containing a coordination of benefits provision. *Id.* Auto Club alleges that the Plan is primarily liable for Alice Guetzka's medical expenses and that the Plan has not paid such benefits as required by Michigan Compiled Laws Section 500.3109a and *Federal Kemper*. Thus plaintiff brings this action to enforce compliance with Michigan law. No federal claim is alleged.

The plaintiff and defendant do not have diverse citizenship. Consequently, defendant may remove this action only if it arises under the Constitution, treaties or laws of the United States. 28 U.S.C. § 1441(b). Under the well-pleaded complaint rule, a case does not arise under federal law unless plaintiff's complaint establishes a federal claim.[1] *Taylor* v. *Anderson*, 234 U.S. 74, 75-76 (1914). This rule applies even if plaintiff's state law

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[1] **The "well-pleaded complaint" rule applies to this Court's original jurisdiction as well as its removal jurisdiction. *Franchise Tax Board of California* v. *Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1, 10 n.9 (1983).**

claim is pre-empted by federal law. *Franchise Tax Board of California* v. *Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1, 14 (1983) ("a case may not be removed to federal court on the basis of a federal defense, including the defense of pre-emption"). Some claims pre-empted by ERISA, however, are removable even though plaintiff's complaint is based solely upon state law. *Metropolitan Life Insurance Co.* v. *Taylor*, 107 S. Ct. 1542, 1547 (1987). Nonetheless, "ERISA pre-emption, without more, does not convert a state claim into an action arising under federal law." *Metropolitan Life*, 107 S. Ct. at 1547 (citing *Franchise Tax Board*, 463 U.S. at 25-27).

In *Metropolitan Life*, the Supreme Court held that a state law claim is removable to federal court notwithstanding the well-pleaded complaint rule when 1) the plaintiff's claim is pre-empted by ERISA and 2) the plaintiff's claim falls within the scope of Section 502(a) of ERISA. *Metropolitan Life*, 107 S. Ct. at 1547. If both conditions are satisfied, the claim is removable to federal court even though plaintiff's complaint does not expressly allege a violation of federal law. *Id.* In this case, the requirements for removal under *Metropolitan Life* have not been fulfilled.

First, Auto Club's claim is not pre-empted by ERISA. *See Northern Group Services Inc.* v. *Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied sub nom. Northern Group Services Inc.* v. *State Farm Mutual Automobile Insurance Co.*, 108 S. Ct. 1754 (1988). In *Northern Group Services*, the Sixth Circuit noted that Section 514(a) of ERISA pre-empts state laws that relate to employee benefit plans. *Id.* at 87-88. However, state laws that regulate "insurance, banking, or securities" are not pre-empted. 29 U.S.C. § 1144(b)(2)(A). On the basis of this "savings" clause, the Sixth Circuit determined that

ERISA does not pre-empt Michigan law requiring a health or accident insurer to bear primary liability for loss under a coordination of benefits clause. *Id.* at 89-90.

Moreover, it is not clear that Auto Club's claim in this case falls within Section 502(a). Section 502(a)(1) provides that:

> A civil action may be brought —
>
> (1) by a participant or beneficiary —
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C. § 1132(a)(1).[2]

In order to bring a claim under Section 502(a)(1), Auto Club must be a participant or beneficiary of the employee benefit plan. *See* 29 U.S.C. § 1132(a)(1). It is not clear that Auto Club is a participant in the employee benefit plan at issue.[3] *See* 29 U.S.C. § 1002(7).

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[2] Section 502(a)(2)-(6) also provides for other actions not relevant here. *See* 29 U.S.C. § 1132(a)(2)-(6).

[3] As a subrogee of a participant (Alice Guetzka, as wife and dependent of employee David Guetzka), Auto Club may have the right to sue the plan under Section 502(a). *See Misic* v. *Building Serv. Employees Health and Welfare Trust*, 789 F.2d 1374, 1378-79 (9th Cir. 1986); *Hermann Hosp.* v. *MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1289-90 (5th Cir. 1988); *Wisconsin Dept. of HHS* v. *Upholsterers Int'l Union Health and Welfare Fund*, 686 F. Supp. 708, 713-14 (W.D. Wis. 1988). *But see Northeast Dept. ILGWU Health and Welfare Fund* v. *Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 154 n.6 (3d Cir. 1985). This Court has no jurisdiction in any event, however, because plaintiff's claim is not pre-empted by ERISA, a condition for removal jurisdiction under *Metropolitan*.

Moreover, there is no indication that Auto Club is a beneficiary of the medical benefit plan. Since Auto Club may not be able to bring this action under Section 502(a), the second condition also has not been unquestionably satisfied.

CONCLUSION

Auto Club pleads a state law cause of action only, thus the Court will remand the proceedings to the state court in which this action originated pursuant to Title 28 United States Code Section 1447(c).

/s/ BENJAMIN F. GIBSON
U.S. DISTRICT JUDGE

DATED: December 21, 1988

STIPULATION AND ORDER FOR EXTENSION OF NOVEMBER 10, 1986 ORDER TO HOLD MATTER IN ABEYANCE

(United States District Court —
Western District of Michigan — Southern Division)

(Dated May 19, 1988)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, v. PENT-WATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant — Federal District Court Case No. _____; Circuit Court Case No. 86-2900-CK, Hon. Terrence R. Thomas, Circuit Court Judge)

For the reason that plaintiff-appellee has filed a petition for rehearing *en banc* of the U.S. District Court of Appeals, 6th Circuit, recent decision in the case of *Northern Group Services, Inc.* vs *State Farm Mutual Automobile Insurance Company*, No. 85-75383 (D. Mich., June 2, 1986), the parties hereto stipulate and agree that this Court's order to hold matter in abeyance dated November 10, 1986, be extended until such time as a final disposition has been rendered in the U.S. Court of Appeals for the 6th Circuit.

BRANDT, HANLON, BECKER, LANCTOT,
McCUTCHEON, MARTIN & SCHOOLMASTER
Attorneys for Plaintiff
By: /s/ David J. Lanctot (P-16378)
Business Address:
1700 First Federal Building
Detroit, Michigan 48226 Dated: 5/2/88

CLARY, NANTZ, WOOD,
HOFFIUS RANKIN & COOPER
Attorneys for Defendant
By: /s/ Stanley J. Stek (P-29332)
Business Address:
500 Calder Plaza
Grand Rapids, Michigan 49503 Dated: 4/29/88

At a session of said Court held in the Federal Building, City of Grand Rapids, Kent County, Michigan, on the 19th day of May, 1988.

PRESENT: HONORABLE BENJAMIN F. GIBSON,
U.S. District Judge.

IT IS SO ORDERED.

/s/ Benjamin F. Gibson,
U.S. District Judge

ORDER TO HOLD MATTER IN ABEYANCE

(United States District Court —
Western District of Michigan — Southern Division)

(Dated November 10, 1986)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, v. PENT-WATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant — Federal Case No. G86-685, Hon. Benjamin F. Gibson; Circuit Court Case No. 86-2900-CK)

At a session of said Court held in the Federal Building in the City of Grand Rapids, County of Kent, State of Michigan, on the 10th day of November, 1986.

PRESENT: HONORABLE BENJAMIN F. GIBSON,
U.S. District Judge

The parties, through their respective counsel, having stipulated that this matter may be held in abeyance pending the decision of the United States Court of Appeals, Sixth Circuit in *Northern Group Services, Inc.* v *State Farm Mutual Automobile Insurance Co.*, No. 85-75383 (D. Mich., June 2, 1986), the parties having further stipulated that arbitration of the matter and discovery proceedings in the matter shall also be held in abeyance during this period of time with new dates for the completion of discovery and arbitration to be assigned by the court, and that this period of abeyance shall continue until such time as one of the parties notifies the court that the United States District Court for the Sixth Circuit has rendered a decision in the *Northern Group Services* case, and the court being otherwise duly advised in the premises, NOW, THEREFORE,

IT IS HEREBY ORDERED AND ADJUDGED that this matter including arbitration and discovery proceedings shall

be held in abeyance until such time as the court is notified that the United States District Court for the Sixth Circuit has reached a decision in the *Northern Group Services* case.

/s/ Hon. Benjamin F. Gibson

Dated: November 10, 1986

STIPULATION TO HOLD MATTER IN ABEYANCE

(United States District Court —
Western District of Michigan — Southern Division)

(Dated October 31, 1986)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff, v. PENT-WATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN, Defendant — Federal Case No. G86-685, Hon. Benjamin F. Gibson; Circuit Court Case No. 86-2900-CK)

NOW COME the parties, by and through their respective counsel of record, and hereby stipulate and agree that this matter may be held in abeyance pending the decision of the United States Court of Appeals, Sixth Circuit in *Northern Group Services, Inc.* v. *State Farm Mutual Automobile Insurance Co.*, No. 85-75383 (D. Mich., June 2, 1986) for the reason that the parties mutually agree that the decision of the United States Court of Appeals for the Sixth Circuit may be dispositive of the issues in this case.

It is further stipulated and agreed that this abeyance shall include arbitration of the matter and discovery proceedings and that new dates for the completion of discovery and arbitration may be assigned by the court.

The parties further stipulate and agree that the period of abeyance of this matter shall be terminated by the notification of the court by either party that the United States District Court for the Sixth Circuit has rendered a decision in the *Northern Group Services* case.

DICKINSON, BRANDT, HANLON,
BECKER & LANCTOT
Attorneys for Plaintiff
By: /s/ David J. Lanctot (P 16378)

Business Address:
2000 First Federal Building
1001 Woodward Avenue
Detroit, MI 48226
Dated: 10/31/86

CLARY, NANTZ, WOOD, HOFFIUS,
RANKIN & COOPER
Attorneys for Defendant
By: /s/ Stanley J. Stek (P-29332)
Business Address:
400 Calder Plaza
Grand Rapids, MI 49503
Dated: 10/30/86

ORDER DENYING REHEARING

(State of Michigan — Supreme Court)

(Entered October 21, 1993)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff-Appellant, v FREDERICK & HERRUD, INC., Defendant-Appellee — SC: 93816; CoA: 135974; LC: 82-246269)

Michael F. Cavanagh, Chief Justice;
Charles L. Levin, James H. Brickley, Patricia J. Boyle, Dorothy Comstock Riley, Robert P. Griffin, Conrad L. Mallett, Jr., Associate Justices.

In this cause, a motion for rehearing is considered and, it is hereby DENIED.

(Certification Omitted)

ORDER DENYING REHEARING

(State of Michigan — Court of Appeals)

(Dated April 13, 1992)

(Auto Club Ins Assn v Frederick & Herrud Inc — Docket #135974; L.C. #82246269CK)

Roman S. Gribbs, Presiding Judge;
Martin M. Doctoroff, Maureen Pulte Reilly, Judges

The Court orders that the motion for rehearing is DENIED.

/s/ Roman S. Gribbs

A true copy entered and certified by Ella Williams, Chief Clerk, on April 13, 1992.

/s/ Ella Williams
(SEAL) Chief Clerk

ORDER DENYING REHEARING

(State of Michigan — Supreme Court)

(Entered October 21, 1993)

(AUTO CLUB INSURANCE ASSOCIATION, Plaintiff-Appellant, v PENTWATER WIRE PRODUCTS, INC., Defendant-Appellee — SC: 93925; CoA: 126174; LC: 86-2900)

Michael F. Cavanagh, Chief Justice;
Charles L. Levin, James H. Brickley, Patricia J. Boyle, Dorothy Comstock Riley, Robert P. Griffin, Conrad L. Mallett, Jr., Associate Justices.

In this cause, a motion for rehearing is considered and, it is hereby DENIED.

(*Certification Omitted*)

ORDER DENYING REHEARING

(State of Michigan — Court of Appeals)

(Dated April 2, 1992)

(AUTO CLUB INS v PENTWATER WIRE PRODUCTS, INC. — Docket #126174; L.C. #86002900)

Robert J. Danhof, J., Presiding Judge;
Martin M. Doctoroff, Thomas J. Brennan, Judges

The Court orders that the motion for rehearing is DENIED.

/s/ Robert J. Danhof

A true copy entered and certified by Ella Williams, Chief Clerk, on April 2, 1992.

(SEAL)

/s/ Ella Williams
Chief Clerk

ACIA's NO-FAULT POLICY: *FREDERICK & HERRUD*

"In consideration of the reduced premium for Personal Protection Insurance, and a presumption that medical benefits are provided by another source, and provided the Insurance Declaration Certificate or Policy Change Endorsement indicates Coordinated Medical Benefits, the Company agrees with the named insured that under the Medical Benefits Coverage, sums paid or payable to or on behalf of the named insured or any relative domiciled in the same household shall be reduced by any amount paid or payable under any valid and collectible individual, blanket or group disability or hospitalization insurance, medical, surgical or hospital direct pay or reimbursement health care plan, worker's compensation law or disability law of a similar nature, or any other State or Federal Law, or automobile or premises insurance affording medical expense benefits."

FREDERICK & HERRUD SUMMARY PLAN DESCRIPTION

SECTION 21
CO-ORDINATION OF BENEFITS

In addition to the benefits payable under this plan, sometimes an employee or dependent is entitled to benefits for the same hospital or medical expenses under the group fault or no-fault auto insurance, individual no-fault auto insurance, medicare or another group plan. Should this type of duplication occur, the benefits under this plan will be co-ordinated so that the total benefits from all plans will not exceed the hospital or medical expenses actually incurred. In all cases employees with no-fault auto insurance coverage, the auto insurance carrier will be primary.

When you or a dependent become eligible for Medicare, any amounts payable under this plan will no longer be co-ordinated with Medicare but will be directly reduced by the amounts payable for the same expenses under Parts A and B of Medicare. A person is considered to be enrolled in both Parts A and B of Medicare whether or not they actually are so enrolled. The Company will notify the employee of their eligibility for medicare benefits by Certified Letter and failure to do so will result in elimination of this coordination.

* * *

* * * you or any relative while occupying a motor vehicle owned or registered by you or their employer for which security is maintained as required under the provisions of the Code;

any relative entitled to Personal Protection Insurance Benefits as a person named under the terms of any other policy;

any person, other than you or any relative, entitled to Personal Protection Insurance Benefits under the terms of any other policy;

the owner or registrant of a motor vehicle involved in the accident who has failed to maintain security on that motor vehicle as required by the Code.

This insurance does not apply to bodily injury or property damage:

suffered intentionally or caused intentionally by any person claiming benefits.

This insurance does not apply to property damage:

to any vehicle and its contents, including trailers, designed for operation upon a public highway by power, other than muscular power, unless the vehicle is parked so as not to cause unreasonable risk of the property damage which occurred;

to any property owned by you or a relative;

to the property of any person who is using the insured motor vehicle without your expressed or implied consent;

to any utility transmission lines, wires or cables arising from the failure of a municipality, utility

company, or cable television company to comply with the requirements of Michigan law.

LIMITS OF LIABILITY

PERSONAL PROTECTION INSURANCE. Our liability for Personal Protection Insurance Benefits payable to or on behalf of any one person who sustains bodily injury in any one motor vehicle accident is limited as set out below.

MEDICAL BENEFITS (ALLOWABLE EXPENSES) shall include reasonable and customary charges for semi-private hospital accommodations except when the insured person requires special care; funeral and burial expenses not to exceed $1,000;

If the Declaration Certificate shows Coordinated Medical Benefits, sums paid or payable to or for you or any relative shall be reduced by any amount paid or payable under any valid and collectible: individual, blanket or group disability or hospitalization insurance; medical, surgical or hospital direct pay or reimbursement health care plan; Workers' Compensation Law, disability law of a similar nature, or any other state or federal law; or car or premises insurance affording medical expense benefits.

WORK LOSS BENEFITS shall include payment for loss which occurs during the life of the insured person and within three years of the date of the accident; loss of services benefits not to exceed $20 per day;

Benefits payable for loss of income from work shall be reduced by 15%. If the insured person's income tax advantage is less than 15% the actual percentage shall apply;

After the application of the above limits, the combined total amount payable for Work Loss in any

30-day period and the income earned shall not exceed the maximum amount established under the Code. If greater, the amount shown on the Declaration Certificate will be paid. The combined total limit shall be reduced pro rata for any period of less than 30 days;

If the Declaration Certificate shows Coordinated Work Loss Benefits, sums paid or payable to you or any relative for loss of income from work shall be reduced by any amount paid or payable under any valid and collectible: individual, blanket, group accident or disability insurance; salary or wage continuation plan; Workers' Compensation Law, disability law of a similar nature, or any other state or federal law.

SURVIVORS' LOSS BENEFITS shall include payment for loss which occurs after the death of the insured person and within three years of the date of the accident; loss of services benefits not to exceed $20 per day;

After the application of the above limits, the combined total amount payable in any 30-day period for Survivors' Loss shall not exceed the maximum amount established under the Code.

We will subtract benefits provided or required to be provided under the laws of any state or federal government from the benefits otherwise payable under this coverage even though the insured person has failed to apply for them. It is the obligation of the insured person to apply for any benefits provided or required to be provided under the laws of any state or federal government. It is also the obligation of the insured person to reapply, appeal or file suit for those governmental benefits if the initial application is rejected.

Amounts payable under Personal Protection Insurance shall be reduced by any deductible stated on the Declaration Certificate. The deductible applies only to you or your relatives and shall not exceed the sum of $300 in any one accident.

PROPERTY PROTECTION INSURANCE. Regardless of vehicles insured or policies held, the Limit of our Liability under this coverage for all property damage from one accident is $1,000,000. Payment is limited to the lesser of reasonable repair costs or replacement costs less depreciation and, where applicable, the value of loss of use.

PENTWATER EMPLOYEE BENEFIT PLAN

* * *

A Plan without a coordinating provision shall always be deemed to be the primary Plan. If all or any other Plan has such a provision that makes This Plan primary, then:

(1) the Plan covering the patient directly, rather than as an Employee's Dependent, is primary and the others secondary.

(2) if a child is covered under both parents' plans, the father's is primary.

(3) if neither (1) nor (2) applies, the plan covering the patient longest is primary.

(4) no-fault Auto coverage is always considered to be the primary Plan, and This Plan shall be deemed to provide only "excess insurance."

When This Plan is the secondary Plan and its payment is reduced to consider the primary Plan's benefits, a record shall be kept of the reduction. This amount shall be used to increase This Plan's payments on the patient's later claims in the same calendar year — to the extent there are Allowable Expenses that would not otherwise be fully paid by This Plan and the others.

(2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under This Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all

other Plans, except as provided in item (3) immediately below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

29 USC § 1144

§ 1144. OTHER LAWS

(a) *Supersedure; effective date*

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) *Construction and application*

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(2)

No. 93-1180

Supreme Court, U.S.
FILED
FEB 14 1994
OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1993

AUTO CLUB INSURANCE ASSOCIATION,
Petitioner,
v.
PENTWATER WIRE PRODUCTS, INC.,
Respondent.

AUTO CLUB INSURANCE ASSOCIATION,
Petitioner,
v.
FREDERICK & HERRUD, INC.,
Respondent.

BRIEF IN OPPOSITION
ON BEHALF OF FREDERICK & HERRUD, INC.
(now known as Thorn Apple Valley, Inc.)

AND APPENDIX

BRADLEY T. RAYMOND
Counsel of Record
FINKEL, WHITEFIELD & SELIK, P.C.
Attorneys for Respondent
32300 Northwestern Highway, Suite 200
Farmington Hills, Michigan 48334-1567
(313) 855-6500

Interstate Brief & Record Company, *a division of* North American Graphics, Inc.
1629 West Lafayette Boulevard, Detroit, MI 48216 (313) 962-6230

31 pp

COUNTER-STATEMENT OF QUESTIONS PRESENTED

I.

WHETHER FEDERAL COMMON LAW UNDER ERISA ALLOWS A STATE COURT TO CREATE A REMEDY IN FAVOR OF A NO-FAULT AUTO INSURANCE CARRIER AGAINST AN EMPLOYER-SPONSOR OF AN ERISA WELFARE BENEFIT PLAN DESPITE THE FAILURE OF CONGRESS TO PROVIDE SUCH A REMEDY IN SECTION 502 OF ERISA.

II.

WHETHER FEDERAL COMMON LAW UNDER ERISA ALLOWS A NO-FAULT AUTO INSURANCE CARRIER TO BRING A SUBROGATION ACTION IN STATE COURT AGAINST THE EMPLOYER-SPONSOR OF AN ERISA WELFARE BENEFIT PLAN.

III.

WHETHER, ASSUMING A CAUSE OF ACTION AND REMEDIAL AUTHORITY EXIST, FEDERAL COMMON LAW UNDER ERISA REQUIRES THAT A DISPUTE OVER COVERAGE BETWEEN AN ERISA WELFARE BENEFIT PLAN AND A NO-FAULT AUTO INSURANCE POLICY, BOTH CONTAINING COORDINATION OF BENEFITS PROVISIONS, MUST BE RESOLVED IN FAVOR OF THE AUTO INSURANCE CARRIER.

PARTIES TO THE PROCEEDINGS

The parties to the proceedings below are listed in the caption. Respondents are not, however, "self-insured welfare benefit plans," as asserted by Petitioner. Rather, they are corporations which have sponsored self-insured welfare benefit plans for their employees.

Respondent Frederick & Herrud, Inc., has been known as Thorn Apple Valley, Inc., for many years. This fact was reflected in the case caption when this matter was previously before the Court during the 1989 Term. *Thorn Apple Valley, Inc.* v. *Auto Club Insurance Association*, 489 U.S. 996 (1990). Neither Frederick & Herrud, Inc., nor Thorn Apple Valley, Inc. have parent companies, affiliated companies or nonwholly owned subsidiaries.

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STATUTES:

Sections 502 and 514 of the Employee Retirement Income Security Act of 1974, as amended 29 U.S.C. §§ 1132 and 1144 ..... *passim*

Section 3109a of Michigan's no-fault auto insurance law, MICH. COMP. LAWS § 500.3109a 1, 3, 4

No. 93-1180

In The

Supreme Court of the United States

October Term, 1993

AUTO CLUB INSURANCE ASSOCIATION,
Petitioner,
v.
PENTWATER WIRE PRODUCTS, INC.,
Respondent.

AUTO CLUB INSURANCE ASSOCIATION,
Petitioner,
v.
FREDERICK & HERRUD, INC.,
Respondent.

BRIEF IN OPPOSITION
ON BEHALF OF FREDERICK & HERRUD, INC.
(now known as Thorn Apple Valley, Inc.)

Respondent Frederick & Herrud, Inc. (Frederick), respectfully requests the Court to deny the petition for certiorari, which seeks review of the Michigan Supreme Court's decision reported at 443 Mich. 358; 505 N.W.2d 820 (1993).

STATUTORY PROVISIONS

The decision of the Michigan Supreme Court below was based on that court's construction of Section 3109a of Michigan's no-fault automobile insurance law. MICH. COMP. LAWS § 500.3109a.

In addition, resolution of the federal issues raised in the petition and below, assuming the Court chooses to consider them, entails interpretation of Sections 502 and 514 of the Employee Retirement Income Security Act

of 1974, as amended. 29 U.S.C. §§ 1132 and 1144. Section 3109a of Michigan's no-fault insurance law and Section 502 of ERISA were omitted from the Appendix to the Petition. They are reprinted here in A-1–A-10.

STATEMENT OF THE CASE[1]

In 1982, Petitioner Auto Club commenced this action in Michigan state court. It invoked state law in an effort to compel Respondent Frederick[2] to reimburse it for auto insurance benefits paid to seven Frederick employees who were also beneficiaries of the company's self-insured welfare benefit plan. These seven insureds had been injured in auto accidents in 1980 and 1981. Auto Club paid no-fault benefits to them under auto insurance policies issued under Michigan's no-fault auto insurance law. Auto Club claimed that Frederick was required to reimburse it for all of the insurance benefits it paid despite a provision in Frederick's plan which states that "in all cases [involving] employees with no-fault auto insurance coverage, the auto insurance carrier will be primary."

Auto Club initially based its claim against Frederick entirely on Michigan law. The precise theory of law proved elusive as the litigation proceeded. The initial complaint mentioned only general notions of contract law. Several years later, before the Michigan Court of Appeals, Auto Club successfully argued that it could recover from Frederick because of policies emanating

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1 We are generally satisfied with the summary of facts set forth in the opinion of the Michigan Supreme Court below. This additional summary is provided only to clarify the posture of this litigation.

2 Frederick, or Thorn Apple Valley, Inc., as it is now known, is a Michigan-based meat packing company.

from Section 3109a of Michigan's no-fault auto insurance law. 145 Mich. App. 722; 377 N.W.2d 902 (1985). That provision requires that auto insurers in Michigan offer insureds the option of buying cheaper no-fault insurance coverage with "deductibles and exclusions reasonably related to other health and accident coverage on the insured." MICH. COMP. LAWS § 500.3109a. As late as 1992, however, Auto Club successfully asserted in state court litigation unrelated to this case that its right to recover no-fault benefit payments from its insureds' employer-provided health plans was contractual in nature after all — in order to benefit from Michigan's relatively long contract statute of limitations. *See Auto Club* v. *New York Life Insurance Co.*, 440 Mich. 126; 485 N.W.2d 695 (1992).

In either case, all state law formulations of Auto Club's claim against Frederick obviously "relate to" Frederick's self-insured employee benefit plan and, hence, were preempted by ERISA. This conclusion was ultimately sustained by this Court in this case in 1990, 489 US 996 (1990), and, on remand, by the Michigan Court of Appeals in 1991, 191 Mich App 471; 479 N.W.2d 18 (1991).

After the Michigan Court of Appeals confirmed that Auto Club's state law claims against Frederick were preempted, Auto Club then shifted course and argued that it could still recover from Frederick — but now directly under ERISA itself. But, since ERISA does not provide a remedy for disputes over coverage between ERISA plans and coverages governed by state law, Auto Club urged that a state law doctrine of prorated liability should be imported into ERISA jurisprudence and applied in this dispute — as a matter of federal common law.

In the decision which Auto Club now urges this Court to review the Michigan Supreme Court rejected Auto

Club's effort to resuscitate its suit against Frederick by relabeling it a federal common law claim. Citing Michigan public policy favoring employer sponsorship of employee benefit plans, and federal cases holding that ERISA coverage disputes should generally be resolved in accordance with the terms of the pertinent ERISA plan, the court decided that the provision in Frederick's plan which states that auto insurance must provide primary coverage for auto accidents involving plan beneficiaries "must be given its clear meaning without the creation of any artificial conflict [with Auto Club's no-fault policy] based upon [MICH. COMP. LAWS § 500.3109a]." 443 Mich at 387; 505 N.W.2d at 833. Noting that "there is a considerable state interest in facilitating the creation and voluntary funding of [welfare plans by employers]," the court concluded that MICH. COMP. LAWS § 500.3109a "does not reach an ERISA plan with a [coordination of benefits] clause where that clause is unambiguous." 443 Mich at 387-88; 505 N.W.2d at 833. In reaching this conclusion, the court overruled an earlier decision in *Federal Kemper Insurance Co* v. *Health Ins. Administration, Inc.*, 424 Mich. 537; 383 N.W.2d 590 (1986), in which that court had held that auto carriers could sue health benefit plans for reimbursement on the theory that this furthered the underlying policies of Michigan's no-fault auto insurance law. 443 Mich. at 390; 505 N.W.2d at 834.

Auto Club now urges this Court to decide that federal law must be construed to afford it a remedy against Frederick in this case.

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REASONS WHY THE PETITION SHOULD BE DENIED

I.

SINCE AUTO CLUB HAS NO ERISA CAUSE OF ACTION AGAINST FREDERICK TO BEGIN WITH THERE IS NO NEED TO CONSIDER THE PARAMETERS OF FEDERAL COMMON LAW UNDER ERISA.

The parties here have not chosen a "narrow battlefield," leaving only the abstract issue formulated by Auto Club for consideration. In fact, we have long disputed that a cause of action under ERISA even exists between Auto Club and Frederick, much less one which would necessitate the examination of the federal common law issues determined by the court below. *See generally Mertens* v. *Hewitt Associates, Inc.*, 508 U.S. ___; 113 S.Ct. 2063, 2067 (1993). We continue to contend that in order to reach the federal common law issues decided by the court below (or those raised in the petition), a court must consider whether ERISA permits Auto Club to sue Frederick in the circumstances of this case — at all. Since maintenance of such a cause of action by Auto Club cannot be squared with the language of ERISA or with previous decisions of this Court, review of the question of how federal law might resolve the putative conflict between Auto Club's insurance policies and Frederick's ERISA plan is hypothetical, at best.

This past Term this Court reaffirmed that claims and remedies under ERISA are limited to those specifically set forth in the statute's "comprehensive and reticulated" civil enforcement provision. *See Mertens* v. *Hewitt Associates, Inc.*, 508 U.S. ___; 113 S.Ct. 2063 (1993). In the face of this "carefully crafted and detailed enforcement scheme," the Court stated that it is "unwilling to infer causes of action in the ERISA context." 113 S.Ct. at 2067; *see also Massachusetts Mutual Life Insurance Co.* v.

Russell, 473 U.S. 134, 146-47 (1985); *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 54 (1987).[3]

Vague notions of "federal common law" provide no detour around ERISA's civil enforcement scheme. True enough, the legislative history underlying ERISA indicates that Congress intended that a "body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. 29942 (remarks of Senator Javitz), *quoted in Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. at 56; *see also Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 110 (1989). But, "the authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute." *Mertens* v. *Hewitt Associates, Inc.*, 508 U.S. at ___; 113 S.Ct. at 2070.

To allow Auto Club to maintain its claim against Frederick under federal common law would require this Court to do just that: impermissibly revise the text of the statute. ERISA does not explicitly provide a remedy for Auto Club against Frederick in this case.[4] Auto Club, and other auto insurers, are plainly not among the "persons empowered to bring a civil action" under ERISA. Nor is an action by an auto insurance company seeking

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3 The unwillingness of this Court to legislate new causes of action under statutes containing comprehensive enforcement and remedial provisions is not limited to ERISA litigation. *See also Northwest Airlines* v. *Transport Workers*, 451 U.S. 77, 97 (1981) ("the judiciary may not in the face of such comprehensive legislative schemes, fashion new remedies that might upset carefully considered legislative programs").

4 The one district court that has attempted to fashion a federal common law remedy against an ERISA plan and in favor of a Michigan no-fault auto insurer candidly conceded that "the ERISA statute itself does not provide an answer." *Auto Owners Insurance Co.* v. *Thorn Apple Valley, Inc.*, 818 F.Supp. 1078, 1081 (W.D. Mich., 1993), *appeal docketed*, No. 93-1606 (6th Cir. May 5, 1993). That should have been enough to end that litigation, a contention we are currently urging to the Sixth Circuit.

to recover no-fault insurance benefit payments from an ERISA plan among those actions comprehended by the six civil actions enumerated in Section 502. While Congress could have, it did not provide for "litigation when a plan subject to ERISA interlocks with coverage governed by state law." See *Foster-McGaw Hospital* v. *Welfare Fund*, 925 F.2d 1023, 1025 (7th Cir. 1991), cert. denied, 502 U.S. ___; 112 S.Ct. 74 (1991). Courts should not be in the business of revising acts of Congress where a litigant believes the legislation does not go far enough.

No good reason exists in this case for usurping the power of Congress, and discarding the statute and previous decisions of this Court construing it, in order to infer a new cause of action for Michigan automobile insurance carriers which Congress could have provided, but did not see fit to enact. Without a cause of action against Frederick, the question Auto Club has formulated for review is meaningless.

II.

EQUITABLE SUBROGATION CLAIMS ARE NOT PROVIDED UNDER ERISA NOR WOULD THEY BE WITHIN THE JURISDICTION OF STATE COURTS.

Review of the abstractions presented in the petition would arguably also require this Court to consider the existence of a federal subrogation remedy under ERISA, an equitable remedy which is nowhere mentioned in the statute and which no federal circuit has recognized. In the decision below, the Michigan Supreme Court sidestepped the absence of a statutory remedy in ERISA for Auto Club's dispute with Frederick and concluded that Auto Club could sue Frederick as the "subrogee of its insureds' right to seek payment from their ERISA plans." 443 Mich. at 370-72; 505 N.W.2d at 825-826. Subrogated to the plan rights of its insureds, Auto Club could then presumably "step into their shoes" and sue Frederick for benefits under Section 502(a)(1)(B) of ERISA. There

are at least three reasons why subrogation is unavailable to Auto Club in this case:

1. Subrogation is a creature of state law. *See, e.g., Auto Club* v. *New York Life Insurance Co.*, 440 Mich. 126, 132-33; 485 N.W.2d 695, 698 (1992). There is no generally recognized federal subrogation remedy. But, if applied to self-insured ERISA plans, state subrogation doctrines are preempted by ERISA. *See FMC Corp.* v. *Holliday*, 498 U.S. 52 (1990). Accordingly, subrogation must either be available to Auto Club directly under ERISA, or not at all.

2. But, even if subrogation can be obtained directly under ERISA, it is nonetheless unavailable in state court. Subrogation is an equitable remedy. *See, e.g., French* v. *Grand Beach Co.*, 239 Mich. 575, 580, 215 N.W. 13 (1927) ("the doctrine of subrogation rests upon the equitable principle that one who, in order to protect a security held by him, is compelled to pay a debt for which another is primarily liable, is to be substituted in the place of and to be vested with the rights of the person to whom such payment is made, without agreement to that effect"); *Machine Parts Corp.* v. *Schneider*, 289 Mich. 567, 574-76, 286 N.W. 831, 834-835 (1939); *Auto Club* v. *New York Life Insurance Co.*, 440 Mich. 126, 132-33 485 N.W.2d 695, 698 (1992); *Federal Kemper Insurance Co.* v. *The Western Insurance Cos.*, 97 Mich. App 204, 208; 293 N.W.2d 765, 767 (1980) ("the proper action here is one in equity for subrogation"). And, while equitable relief may be obtained in an action arising under Section 502(a)(3) of ERISA, actions arising under that provision fall within the exclusive jurisdiction of the federal courts. *See* 29 U.S.C. § 1132(e)(1). Thus, if subrogation is available in suits against ERISA plans, then the Michigan state courts nonetheless had no subject matter jurisdiction to consider or apply it here.

3. There is no federal right of subrogation under ERISA in any event. Section 502 of ERISA makes no mention of it. The Michigan Supreme Court in its opinion below ignored the statute and stated that there is a split of authority among the courts regarding whether a subrogation claim can be brought against an ERISA plan by a party which is not expressly empowered to sue under ERISA. 443 Mich. at 370-72; 505 N.W.2d 825-826. In fact, there is no such split of authority.

Concededly, several courts have held that persons or entities may sue, as if they were beneficiaries under ERISA plans, based upon express assignments of plan rights by persons who are themselves plan participants. *E.g.*, *Misic* v. *Building Services Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986); *Herman Hospital* v. *MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988). But, since a "beneficiary" is defined in ERISA as a "person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder," 29 U.S.C. § 1002(7), allowing an assignee — i.e., a person or entity expressly "designated" by a plan participant as entitled to benefits under a plan — to sue as a beneficiary appears faithful to the statutory text. Subrogation, however, occurs by operation of law and is not dependent upon any formal designation by a plan participant. Not surprisingly, no federal circuit so far as we are aware has ever ruled that claims may be brought under ERISA and against ERISA plans by entities claiming to assert plan rights derivatively by way of subrogation. At least one circuit, the Third, has ruled to the contrary. *Allstate Insurance Co.* v. *The Sixty-Five Security Plan*, 879 F.2d 90, 94 (3rd Cir. 1989).

In our 1989 petition for certiorari in this case, we expressly raised the question of whether ERISA pre-

empts Auto Club's subrogation claims. The Court's order granting certiorari and remanding for proceedings consistent with *FMC Corp.* v. *Holliday*, 498 U.S. 52 (1990), 498 U.S. 996 (1990), arguably sustained our position on preemption. It did not invite the Michigan courts to concoct a new federal remedy of subrogation, equitable relief which they would be powerless to provide under Section 502.

III.

THERE IS NO CONFLICT AMONG THE CIRCUITS CONCERNING THE APPLICATION OF FEDERAL COMMON LAW TO COVERAGE DISPUTES BETWEEN ERISA PLANS AND INSURANCE COVERAGES GOVERNED BY STATE LAW.

Citing decisions in which several courts have developed federal common law remedies for priority of coverage disputes *between* ERISA plans, Auto Club asserts that there are conflicting decisions concerning the federal common law issue presented in its petition. This is simply not true.

One ERISA plan can arguably sue another ERISA plan to determine priority of coverage under Section 502(a)(3)(B) of ERISA,[5] which authorizes suits by a plan fiduciary to "enforce" the terms of a plan. *See Winstead* v. *J.C. Penney Co.*, 933 F.2d 576, 578-79 (7th Cir. 1991). It is in the context of suits *between* ERISA plans that there are conflicting decisions concerning how such priority disputes should be determined. *Compare P.M. Group Life Insurance Association* v. *Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir. 1992) (applying "birthday rule"), *with Inter-Valley Health Plan* v. *Blue Cross/Blue Shield of Connecticut*, 16 Cal. App. 4th 60; 19 Cal. Rptr. 2d

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5 State courts, however, would have no subject matter jurisdiction over such a claim. *See* 29 U.S.C. § 1132(e)(1).

782 (1993), cert. denied, 62 U.S.L.W. 3469 (Jan. 18, 1994) (divorce judgment applied instead of "birthday rule"). Petitioner actually cites nothing *but* decisions involving disputes *between* health benefit plans in support of its assertion that this Court should decide whether and how federal common law would resolve a dispute between an ERISA plan and a non-ERISA entity such as an auto insurance company.

This Court recently decided that the proper application of federal common law to resolve disputes *between* ERISA plans did not warrant review. *Blue Cross/Blue Shield of Connecticut v. Inter Valley Health Plan*, 62 U.S.L.W. 3469 (Jan. 18, 1994). There is surely no reason to consider the even more obscure (and largely parochial) question presented in the petition, which was raised in a context in which the very existence of a federal cause of action is doubtful and in which it is more doubtful that the Michigan state courts below even had subject matter jurisdiction.

IV.

THE REMEDY WHICH AUTO CLUB SEEKS TO OBTAIN UNDER FEDERAL COMMON LAW WOULD SUBVERT, RATHER THAN FURTHER, THE POLICIES UNDERLYING ERISA.

The rule which Auto Club urges this Court to adopt as a matter of federal common law[6] would turn ERISA

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6 Although there is no "plain statement" predicating the ruling below on an independent and adequate state ground, *See Michigan* v. *Long*, 463 U.S. 1032 (1983), the finding that the provisions of Frederick's plan should prevail over Auto Club's no-fault policies nonetheless rests largely on the Michigan Supreme Court's construction of state law and considerations of state public policy. The court's reasoning is expressly predicated on a decision not to create an "artificial conflict" between the Frederick plan and Auto Club's no-fault policies "based upon" Section 3109a of Michigan's no-fault

(concluded on page 12)

and its underlying policies upside down. After resolving — we contend erroneously — the question of whether Auto Club has a cause of action against Frederick over which state courts could assert jurisdiction, the Michigan Supreme Court concluded below that in cases of conflict between the provisions in an ERISA employee benefit plan and a no-fault automobile insurance policy, the ERISA plan's provisions should prevail. The court reasoned that the federal policy underlying ERISA encourages rather than discourages the adoption of employee benefit plans and that allowing Auto Club to pursue a claim for reimbursement against Frederick despite what Frederick's ERISA plan clearly provides would tend to discourage Frederick and other employers from providing employee benefit plans for their employees. This is a consideration frequently cited by federal courts in resolving ERISA disputes. *See, e.g., Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987); *McGann* v. *H&H Music Co.*, 946 F.2d 401, 407 (5th Cir. 1991), cert. denied, 506 U.S. ___, 113 S.Ct. 482 (1992); *Musto* v. *American General Corp.*, 861 F.2d 897, 912 (6th Cir. 1988), cert. denied, 490 U.S. 1020 (1989); *Moore* v. *Reynolds Metals Co. Retirement Plan*, 740 F.2d 454, 456-57 (6th Cir. 1984). This reasoning is sound and requires no adjustment by this Court.

Moreover, in those situations where federal courts have proceeded to develop federal common law in resolving claims under ERISA, courts have repeatedly cautioned that they will only do so to "effectuate the

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(*continued from page 11*)

auto insurance law. 443 Mich. at 387; 505 N.W.2d 833. The court also observed that the "federal policy furthers the state interest of fostering the existence of health and welfare benefit plans for its citizens," *id.*, and concluded by overruling an earlier decision, *Federal Kemper Insurance Co.* v *Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986), which was based entirely on state law. 443 Mich. at 390; 505 N.W.2d at 834.

policies underlying ERISA," *see Thomason* v. *Aetna Life Insurance Co.*, 9 F.3d 645, 647 (7th Cir. 1993), or "the statutory pattern enacted by Congress" in ERISA, *UIU Severance Pay Trust Fund* v. *Local 18-U*, 998 F.2d 509, 512 n.10 (7th Cir. 1993). Clearly, the power to develop federal common law under ERISA, according to decisions in several circuits (including the Sixth), does not translate into a license to override or rewrite the plain terms of an ERISA plan. *Cummings by Techmeier* v. *Briggs and Stratton Retirement Plan*, 797 F.2d 383, 390-91 (7th Cir. 1986) ("we are particularly reluctant to fashion a federal common law doctrine of unjust enrichment where such a right would override a contractual provision in a pension plan"); *Moore* v. *Reynolds Metals Co. Retirement Plan*, 740 F.2d 454, 456, 57 (6th Cir. 1984) ("the district court modified impermissibly the plain language of the pension plan").

How adoption of Auto Club's position that federal common law requires that the provision in Frederick's plan making it secondary to auto insurance be voided would further or effectuate ERISA or its underlying policies is beyond us. Frederick's plan expressly provides that its coverage is secondary to automobile insurance coverage whenever a plan participant or beneficiary is involved in an auto accident and has no-fault insurance coverage. The plan language is not susceptible to any rational interpretation compatible with its terms or ERISA which would cause Frederick to pay all or even some of the medical expenses of Auto Club's seven insureds. After more than 10 years of litigation, Auto Club has failed to articulate a single federal policy that would support its request that this Court supplement ERISA with a new federal common law remedy, which would rewrite ERISA plans in Michigan and benefit no one except Auto Club and other Michigan no-fault insurers. *See generally Health Choice* v. *Automotive Employee Benefit Trust*, 988 F.2d 53 (8th Cir. 1993).

The contortions of the statutory text and its underlying policies which Auto Club urges in support of its claim do not merit this Court's consideration in this case.

CONCLUSION

For these reasons, the petition for writ of certiorari should be denied.

Respectfully submitted,

FINKEL, WHITEFIELD & SELIK, P.C.

By: /s/ BRADLEY T. RAYMOND (P27952)
Counsel of Record

32300 Northwestern Highway Suite 200
Farmington Hills, MI 48334-1567
(313) 855-6500

Counsel for Respondent
Frederick & Herrud, Inc.

Dated: February 9, 1994

APPENDIX

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STATUTES INVOLVED[7]

SECTION 3190a OF MICHIGAN'S NO-FAULT AUTO INSURANCE LAW; MICH. COMP. LAWS §500.3109a

Sec. 3109a. An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

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[7] **Petitioner has included in its appendix only Section 514 of ERISA. 29 U.S.C. § 1144.**

SECTION 502
OF THE EMPLOYEE RETIREMENT
INCOME SECURITY ACT OF 1974,
AS AMENDED,
29 U.S.C. § 1132

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin

any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (1) of this section.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if —

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the require-

ments of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpoena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil

actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs, awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan —

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater or —

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 2975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for

the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of —

(A) any breach of fiduciary responsibility under (or other violation of) part 4 by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person, the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1) —

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (1)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that —

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(3)

No. 93-1180

Supreme Court, U.S.
FILED
FEB 14 1994
OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1993

AUTO CLUB INSURANCE ASSOCIATION,

Petitioner,

v.

PENTWATER WIRE PRODUCTS, INC. SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN,

Respondent.

AUTO CLUB INSURANCE ASSOCIATION,

Petitioner,

v.

FREDERICK & HERRUD, INC.,

Respondent.

On Petition For Writ Of Certiorari To The Michigan Supreme Court

BRIEF IN RESPONSE TO PETITION

STEPHEN WASINGER
HONIGMAN MILLER SCHWARTZ AND COHN
2290 First National Building
Detroit, Michigan 48226
(313) 256-7726

Counsel for Respondent

QUESTIONS PRESENTED FOR REVIEW

Respondent Pentwater Wire Products, Inc. Self-Funded Employee Health Benefit Plan (the Respondent Plan) objects to the form and substance of the questions presented in Petitioner's Petition For Writ of Certiorari to the United States Supreme Court (Petition), and believes the questions should be as follows:

1. Where Petitioner asserted a claim against the Respondent Plan allegedly as the subrogee of a "beneficiary" of an ERISA Plan, can Petitioner circumvent the express limitations of ERISA Section 502 – which governs the rights of an ERISA Plan "beneficiary" – and, instead, pursue a remedy under the "federal common law" which would conflict with the express language of ERISA Section 502?

2. If Petitioner now proceeds in some capacity other than as a subrogee of an ERISA Plan participant, does this Court have jurisdiction to consider Petitioner's claim where the Michigan Supreme Court would have lacked subject matter jurisdiction to consider such a claim?

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STATEMENT OF THE CASE

Petitioner is an automobile insurer. Respondent is a self-funded ERISA benefit plan. Petitioner insured a woman who claimed to be a beneficiary of Respondent Plan. Petitioner paid medical expenses incurred by its insured after an automobile accident. Petitioner then sought to recover those medical expenses from Respondent Plan. After the Michigan Court of Appeals determined that there was no state law basis for Petitioner's claim, because any state law remedy was preempted by ERISA, Petitioner then asked the Michigan Supreme Court to create a "federal common law" remedy. The Michigan Supreme Court refused to do so. The Michigan Supreme Court concluded that Petitioner could proceed as a subrogee of its insured, but, as a subrogee, Petitioner's rights were governed by the terms of the ERISA Plan. Pet.App. A-28.

Respondent does not agree that Petitioner can properly proceed as a subrogee.[1] However, assuming Petitioner could do so, the Michigan Supreme Court's holding that Petitioner's rights, as subrogee, are governed by the terms of the ERISA Plan is not only correct, it enforces ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), which creates a civil cause of action for a

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[1] As this Court again emphasized in *Mertens v. Hewitt Associates, Inc.*, ___ U.S. ___, 113 S.Ct. 2063, 124 L.Ed.2d 161, 167(1993), claims and remedies under ERISA are limited to those specifically set forth in the statute's "comprehensive and reticulated" civil enforcement provision. Thus, this Court reemphasized, in *Mertens*, 124 L.Ed.2d at 169, its "unwillingness to infer causes of action in the ERISA context. . . ." In essence, the Michigan Supreme Court inferred a cause of action in favor of the subrogee of an ERISA plan participant or beneficiary.

"participant" or "beneficiary" of an ERISA Plan but limits the remedies of a "participant" or "beneficiary" to rights or benefits "under the terms of the plan."

Having failed to persuade the Michigan Supreme Court, Petitioner now attempts to have this court create a new "federal common law" right which would allow Petitioner, as subrogee, to circumvent the terms of the ERISA Plan. The petition lacks merit and should be denied.

FACTUAL BACKGROUND

A. The Nature of the Action Below

This dispute arises out of the payment of medical expenses which were incurred by Alice Guetzka as a result of an automobile accident in June, 1985. At the time of the accident, Ms. Guetzka was insured by Petitioner. Ms. Guetzka was separated from her husband. Petitioner paid those expenses, but Petitioner then sought to recover the expenses from the Respondent Plan. The Respondent Plan denied that it had liability for Ms. Guetzka's medical expenses for two reasons: (1) Mrs. Guetzka was not a "participant" or "beneficiary" of the Respondent Plan, and (2), even if she was, the Respondent Plan did not pay medical expenses arising out of an automobile accident where there was coverage under an automobile insurance policy. Pet.App. A-105.

B. Petitioner's Complaint Against The Respondent Plan

Petitioner filed a one count complaint in a Michigan state court against the Respondent Plan seeking

reimbursement for medical expenses it paid on behalf of its insured. Petitioner alleged that its auto policy contained a provision stating that "sums paid or payable" under Petitioner's policy must be reduced by "any amount paid or payable under any valid and collectible" insurance policy or health care plan. Petitioner then alleged that it owed only secondary coverage to Ms. Guetzka.

Petitioner's prayer for relief contained two requests: (1) a judgment for moneys already paid by Petitioner on behalf of Ms. Guetzka and (2) a judgment declaring that the Respondent Plan, not Petitioner, had liability for all medical expenses incurred in the future.

C. The Respondent Plan's Defenses

The Respondent Plan asserted several defenses to Petitioner's claims, including: (1) Petitioner's claims based on state law were preempted by ERISA; (2) assuming Petitioner's state law claims were not preempted, Ms. Guetzka was not entitled to benefits because she was not covered by the Respondent Plan at the time of the accident.

D. The Federal Court Remand

Respondent Plan removed Petitioner's complaint to federal court. The District Court remanded the case, however, finding – prior to this Court's decision in *FMC Corp. v. Holiday*, 498 U.S. 52 (1990) – that (1) ERISA did not preempt Petitioner's state law claim and (2) there was no federal jurisdiction because "[Petitioner] pleads a state law cause of action only. . . . " Pet.App. A-88. The District Court also observed, in a footnote, that Petitioner Auto

Club might have a right to sue under ERISA Section 502 as a subrogee of a participant or beneficiary, but that it was not necessary to decide this question given the nature of Petitioner's claim. Pet.App. A-87 n.1.

E. The Circuit Court's Judgment

The Circuit Court granted judgment for Petitioner based on (1) its determination that, as a matter of state law, Ms. Guetzka was covered by the Respondent Plan and (2) its determination that, under Section 3109a of the Michigan No Fault Act, Respondent Plan had primary liability for the losses incurred by Ms. Guetzka. The Circuit Court held that Petitioner's state law claims were not preempted by ERISA. *See* Pet.App. A-6 n.11

F. Respondent Plan's Appeal

On appeal, the Michigan Court of Appeals held that ERISA preempted Petitioner's state law claims. Therefore, the Michigan Court of Appeals did not address the Respondent Plan's other arguments based on state law.

G. Petitioner's Application For Leave To Appeal

Petitioner filed an application for leave to appeal to the Michigan Supreme Court and, *for the first time,* raised an issue of federal law. In this application, Petitioner finally conceded that ERISA preempted Section 3109a – thus conceding the very issue presented to the Court of Appeals – but Petitioner contended that it was entitled to prevail against the Respondent ERISA Plan based on

federal common law. In order to establish state court jurisdiction over this new federal claim, Petitioner contended that it was proceeding as a subrogee of its insured. ERISA Section 502(e), 29 U.S.C. § 1132(e), grants state courts "concurrent jurisdiction" over a claim brought by a "participant" or "beneficiary" pursuant to ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

The Michigan Supreme Court agreed that Petitioner could proceed as a "subrogee," but it then concluded that Petitioner did not have a "federal common law" right to seek reimbursement from Respondent Plan. The Michigan Supreme Court correctly observed that, by its express language, the Respondent Plan did not provide coverage for medical expenses arising out of an automobile accident where there was also automobile insurance. It then held that "the ERISA plans' terms control." Pet.App. A-28. The Michigan Supreme Court found that this result not only promoted the policies underlying ERISA but that it also "furthers the state interest of fostering the existence of health and welfare benefit plans for its citizens." Pet.App. A-28.

H. The Respondent Plan

Paragraph 4.17 of the Respondent Plan is entitled "Coordination of Benefits." Paragraph 4.17-3 then states:

> A Plan without a coordinating provision shall always be deemed to be the primary Plan. If all or any other Plan has such a provision that makes This Plan primary, then: * * *
>
> (4) no-fault Auto coverage is always considered to be the primary Plan, and This Plan

> shall be deemed to provide only "excess insurance." [Pet.App. A-105]

Petitioner did not challenge this language; Petitioner simply contended that this language did not apply to it, arguing, initially, that this language was rendered inoperative by Section 3109a of the Michigan No-Fault Act and, later, that this language was rendered inoperative by "federal common law."

I. Michigan Insurance Law Provisions

Prior to filing its brief before the Michigan Supreme Court, Petitioner based its claim on Section 3109a of the Michigan No Fault Insurance Act, M.C.L. 500.3109a, which provides:

> An insurer providing personal protection insurance benefits shall offer . . . deductibles and other exclusions reasonably related to *other health and accident coverage on the insured.* [Emphasis added.]

The Respondent Plan does not provide "other health and accident coverage" within the meaning of this provision, as Petitioner now concedes.

REASONS FOR DENYING THE PETITION

Petitioner's brief does not once cite ERISA Section 502. This demonstrates the fundamental flaw in the petition. ERISA Section 502 governs the rights of a "participant" or "beneficiary" claiming against an ERISA plan,

and ERISA Section 502(a) requires any claim by a "participant" or "beneficiary" to be decided "under the terms of the plan." Assuming Petitioner could proceed as the subrogee of a "participant" or "beneficiary,"[2] Petitioner's claims would be governed by ERISA Section 502. But, as its failure even to cite ERISA Section 502 demonstrates, Petitioner refuses to be bound by ERISA Section 502.

The reason is obvious: ERISA Section 502 does not permit Petitioner to recover any moneys from the Respondent Plan because, "under the terms of the plan," there is no coverage for medical expenses arising out of an automobile accident. Where there is also automobile insurance.

Because it has no remedy under ERISA Section 502, Petitioner wants this Court to create a "federal common law" granting Petitioner rights not granted by ERISA itself. Petitioner argues that this "federal common law" is necessary to promote uniformity. There is no need for a new "federal common law" rule to create uniformity because ERISA Section 502 already provides a uniform federal rule.

Petitioner tries to avoid ERISA Section 502 by arguing that this case is really about a conflict between "coordination of benefit" provisions. But, in this case, there is no conflict. Petitioner created jurisdiction under ERISA by arguing that it was the subrogee of a "participant" or

---

[2] *See* Footnote 1 above. This issue is also addressed in a brief which Frederick & Herrud, Inc. will file in opposition to the petition. Respondent Plan adopts Frederick & Herrud's arguments against establishing the right of Petitioner to proceed as a subrogee of its insured.

"beneficiary."[3] But, as a subrogee, Petitioner has no right to make claims under Petitioner's insurance policy. As subrogee, Petitioner is bound by the terms of the Respondent Plan.

It is possible that in some other case at some other time this Court may be called upon to decide a conflict among other "coordination of benefit" provisions – for example, a conflict between the "coordination of benefit" provisions in two ERISA plans[4] – but this is not that case. ERISA provides a uniform rule governing claims against an ERISA plan by participants, beneficiaries or subrogees. The proposed "federal common law" solution proposed by Petitioner is not only unnecessary, it would effectively overrule ERISA Section 502. The Petition is without merit, and it should be denied.

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[3] If Petitioner is not a "subrogee," then the Michigan Supreme Court lacked subject matter jurisdiction. ERISA Section 502(e), 29 U.S.C. § 1132(e), expressly and unequivocally provides that state courts have "concurrent jurisdiction" over a claim brought by a "participant" or "beneficiary" pursuant to ERISA Section 502(a)(1)(B). Thus, a state court is limited to determining the rights of a "participant" or "beneficiary" "under the terms of" an ERISA Plan. A state court has no jurisdiction to determine rights under some other body of law, federal or state.

[4] *See, e.g., P.M. Group Life Ins. Ass'n v. Western Growers Assurance Trust*, 953 F.2d 543, 547 (9th Cir. 1992). This court recently refused to review a case involving the proper application of federal common law to resolve disputes between ERISA Plans. *Blue Cross/Blue Shield of Connecticut v. Inter Valley Health Plan*, 62 U.S.L.W. 3469 (Jan. 18, 1994).

A. Because Petitioner Can Only Assert A Claim As Subrogee, ERISA Section 502 Provides A Complete, Exclusive Remedy For That Claim, And There Is No Need For This Court To Create A "Federal Common Law" Remedy

At root, Petitioner's argument is founded on a confusion of its separate roles: when it made its state law claim, Petitioner was proceeding as an automobile insurer which had been granted special rights by Section 3109a of the Michigan No-Fault Act against other insurers offering "health and accident coverage." To succeed as an "auto insurer," Petitioner had to argue that the Respondent Plan was an "Insurer" within the meaning of Section 3109a. That claim arose solely under state law. When the Michigan Court of Appeals held that ERISA preempted Petitioner's state law claim, Petitioner abandoned its claims as an auto insurer. Instead, Petitioner argued that: (1) it was entitled to prevail as the "subrogee" of its insured, (2) this new claim as subrogee was founded on federal law, and, therefore, (3) it was not affected by ERISA preemption.

However, Petitioner refused to accept the limits inherent in its status as a subrogee. Instead of standing in the shoes of its insured, taking whatever rights a "participant" or "beneficiary" might have "under the terms of the plan" – as ERISA Section 502 requires – Petitioner argued that it had greater rights created by "federal common law" because of its status as an auto insurer whose insurance policy had a "coordination of benefits" provision which conflicted with the terms of the Respondent Plan. Thus, the new "federal common law" which Petitioner advocated had nothing to do with the rights of

a "participant" or "beneficary." Petitioner's confusion of roles is most evident when Petitioner argues:

> . . . the Michigan Supreme Court misapprehended the nature of the conflict presented to it. The question was not whether § 3109a should be permitted to create an "artificial conflict" (A-28) between the *parties' contracts.* The inapplicability of state law, which necessarily includes state statutes was given. Thus, the conflict was not, and could not be, between § 3109a and the ERISA. Rather, the conflict was between the irreconcilable COB clauses in the *parties' contracts.* The result of the court's failure to appreciate the nature of the conflict created was an almost perfect circularity of reasoning. [Pet.Br. at 11-12. Emphasis added.]

By the "parties' contracts," Petitioner refers, of course, to the Respondent Plan and Petitioner's automobile insurance policy. But, as subrogee, that insurance policy has no status whatsoever. Ms. Guetzka could not attempt to argue for benefits from the ERISA Plan based on alleged rights under her automobile policy; and neither can Petitioner, as subrogee of Ms. Guetzka.

The Michigan Supreme Court did not misapprehend the nature of the conflict presented to it. The Michigan Supreme Court fully understood that, as subrogee, Petitioner was bound by the terms of the Respondent Plan. That is precisely what the Michigan Supreme Court held. Thus, there is no need for some additional "federal common law" to resolve some imagined dispute.

More importantly, any attempt to create a "federal common law" right would frustrate the statutory scheme established by ERISA. ERISA Section 502(a) states:

A civil action may be brought –

> (1) by a participant or beneficiary . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. * * *

This Court has repeatedly emphasized that ERISA Section 502 provides a comprehensive, exclusive enforcement section. *Mertens*, 124 L.Ed.2d at 169, reemphasized this Court's "unwillingness to infer causes of action in the ERISA context, since that statute's carefully crafted and detailed enforcement scheme provides strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly," quoting from *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146-147 (1985). Thus, Section 502(a) provides an exclusive remedy for anyone claiming benefits under an ERISA Plan; and it carefully and deliberately states all of the claims and remedies that can be pursued under ERISA, **all** of the parties that may bring such claims and **all** of the parties that can be deemed liable on such claims. As this Court stated in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 55 (1987):

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely

> undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under a state law that Congress rejected in ERISA. * * *
>
> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.

So too would the federal scheme be "completely undermined" if the subrogee of an ERISA Plan participant were free to obtain remedies under "federal common law" that Congress rejected in ERISA. *See also Mertens,* 124 L.Ed.2d at 169 ("The authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute.").

In its decision, the Michigan Supreme Court confirmed that ERISA Section 502 also serves an important state purpose.

> Moreover, and of equal importance, we are persuaded that the federal policy furthers the state interest of fostering the existence of health and welfare benefit plans for its citizens. Thus, the perceived conflict between state and federal policy is not as marked as plaintiff would have us believe. Earlier we noted that there is no law requiring the establishment or funding of ERISA health and welfare benefit plans. We are also unaware of any state law requiring similar protection. Therefore, there is a considerable state interest in facilitating the creation and voluntary funding of such plans, especially in cases in which there is no automobile no-fault or other insurance to provide benefits. For these reasons,

> we conclude that MCL 500.3109a; MSA 24.13109(1) does not reach an ERISA plan with a COB clause where that clause is unambiguous. [Pet.App. A-28]

In short, there is no need for a new "federal common law" remedy which would change the carefully balanced statutory scheme.

B. Creating A New "Federal Common Law" Would, In Effect, Mandate Benefits Even Though Congress Refused To Do So

The "federal common law" solution should also be rejected because it would directly conflict with Congress' intention to let ERISA Plans themselves determine the benefits that they will provide. As this Court observed in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981), under ERISA, "private parties, not the Government, control the level of benefits. . . . " 451 U.S. at 511.

There can be no doubt that Petitioner's "federal common law" would mandate benefits. Under Petitioner's proposed "federal common law," the ERISA Plan would be forced to pay benefits any time some other insurer tried to shift costs to the ERISA Plan by including a "coordination of benefits" provision in the insurance policy requiring the ERISA Plan to absorb some or all of the medical costs arising out of an automobile accident.

By inserting such a provision in its policy, an auto insurer would create a conflict with any ERISA plan which did not cover automobile accidents. The proposed "federal common law" would then resolve the conflict by forcing the ERISA Plan to pay half of the medical costs. In

other words, the "federal common law" would mandate benefits.

C. There Is No Conflict Among The Circuits On This Issue

Petitioner's brief purports to find a conflict among the circuits on this issue. There is no conflict. None of the cases cited by Petitioner addressed the specific issue addressed by the Michigan Supreme Court and, more importantly, the case which allegedly proves the conflict, *Winstead v. Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. den.*, 488 U.S. 1030 (1989), was decided before this Court's decisions in *FMC Corp.*[5] and *Mertens*. That fact is important because *Winstead* assumed that state law principles could be used to resolve a dispute between an ERISA Plan and an insurer. However, once one accepts that ERISA preempts these state laws – as one must after *FMC Corp.* – *Winstead's* reasoning loses its force. Further, after *Mertens*, *Winstead's* expansive view of the role of "federal common law" is no longer sound.

Winstead's reasoning is especially irrelevant where the auto insurer is not proceeding as auto insurer under state law but, instead, is proceeding as a subrogee of an

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[5] While the Sixth Circuit did suggest, in *Lincoln Mutual Casualty Co. v. Lectron Products, Inc. Health & Welfare Plans*, 970 F.2d 206, 211 (6th Cir. 1992), that a dispute between an auto insurer and an ERISA Plan could be resolved by prorating responsibility for the medical expenses, the Sixth Circuit refused to decide the question. Instead, it remanded to the district court for further consideration.

ERISA plan "participant" or "beneficiary." In that capacity, there simply is no conflict to be resolved by "federal common law"; and any attempt to create a "federal common law" remedy for the auto insurer would effectively "revise the text of the statute," which *Mertens* found to be improper. The rights of the subrogee must be decided solely by reference to the terms of the ERISA Plan itself.

D. Petitioner Cannot Claim Some Different Status In This Court Because The Sole Basis For Jurisdiction To Decide The Federal Claim Was ERISA Section 502(e) Which Only Grants A State Court Concurrent Jurisdiction To Decide Claims Brought Pursuant To ERISA Section 502(a) By A "Participant" or "Beneficiary"

While Petitioner attempts to introduce a conflict between its insurance policy and the ERISA Plan, the Michigan Supreme Court lacked subject matter to resolve this issue. ERISA Section 502(e), 29 U.S.C. § 1132(e), expressly and unequivocally states that state courts only have "concurrent jurisdiction" over a claim brought pursuant to ERISA Section 502(a)(1)(B), namely, a claim brought by a "participant" or "beneficiary" which seeks:

> (B) to recover benefits due him *under the terms of the plan*, to enforce his rights *under the terms of the plan*, or to clarify his rights to future benefits *under the terms of the plan*. . . . [29 U.S.C. § 1132(a)(1)(B). (Emphasis added.)]

Thus, the Michigan Supreme Court did not have jurisdiction to decide a claim not based on ERISA Section 502, and Petitioner cannot attempt to advance such a claim in this court.

CONCLUSION

The Petition should be denied.

HONIGMAN MILLER SCHWARTZ AND COHN
Attorneys for Respondent

By:_____
STEPHEN WASINGER (P25963)
2290 First National Building
Detroit, Michigan 48226
(313) 256-7726

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Supreme Court, U.S.
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No. 93-1180

In The

Supreme Court of the United States

October Term, 1993

AUTO CLUB INSURANCE ASSOCIATION,
Petitioner,

v.

PENTWATER WIRE PRODUCTS, INC.,
and
FREDERICK & HERRUD, INC.,
Respondents.

On Petition for a Writ of Certiorari
to the Michigan Supreme Court

PETITIONER'S MEMORANDUM IN REPLY TO BRIEF IN RESPONSE TO PETITION ON BEHALF OF PENTWATER WIRE PRODUCTS, INC.

DAVID J. LANCTOT
HANLON, BECKER, LANCTOT, McCUTCHEON, SCHOOLMASTER & TAYLOR
2000 First Federal Building
Detroit, Michigan 48226
(313) 237-5656
Co-Counsel for Petitioner

JAMES GEORGE GROSS
Counsel of Record
GROSS & NEMETH
444 Penobscot Building
Detroit, Michigan 48226
(313) 963-8200
Co-Counsel for Petitioner

Interstate Brief & Record Company, *a division of* North American Graphics, Inc.
1629 West Lafayette Boulevard, Detroit, MI 48216 (313) 962-6230

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On Petition for a Writ of Certiorari
to the Michigan Supreme Court

PETITIONER'S MEMORANDUM IN REPLY TO BRIEF IN RESPONSE TO PETITION ON BEHALF OF PENTWATER WIRE PRODUCTS, INC.

In the interest of coherence, the following discussion of Respondent Pentwater's four major contentions will be presented under headings stating the conclusory substance of Petitioner's reply to them.

A. Petitioner Does Not Seek A New Remedy, But Rather A Federal Rule Of Decision Applicable To Actions Seeking The Existing Remedy Set Forth In § 502(a)(1)(B) Of The ERISA.

The gist of Respondent Pentwater's argument seems to be that Petitioner is not truly proceeding as a subrogee of Ms. Guetzka because it is seeking rights greater

than hers; that, in effect, Petitioner is seeking to create a new remedy or a new cause of action. Respondent's argument is premised upon a fundamental misunderstanding of the nature of the dispute and of the question Petitioner presents to this Court.

Rather than address each erroneous premise in Respondent's argument, Pentwater will demonstrate that the same dispositive issue and the same necessity for a federal common law rule to resolve it would exist even if the instant case had been brought by Ms. Guetzka herself rather than by her subrogee.

Let us assume that rather than paying Ms. Guetzka's claim, Petitioner denied it on the basis of the coordination of benefits (COB) clause in its policy (A-10 n 8). Ms. Guetzka's remedy against Respondent would be an action under § 502(a)(1)(B): no one questions her right under the ERISA to maintain such an action in state court. The dispute would be as follows:

(1) Ms. Guetzka would allege that Respondent Plan provides coverage for her medical expenses.

(2) Respondent Plan would answer that it owes no coverage because its COB clause (A-5 n 9) makes Petitioner's coverage primary.[1]

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[1] Respondent mischaracterizes its coverage by asserting that "there is no coverage for medical expenses arising out of an automobile accident [w]here there is also automobile insurance." (Brief in Response to Petition [hereinafter "Pentwater's Brief"], p. 7). Actually, the terms of Respondent Plan *do* provide coverage for such accidents, but only "excess insurance" over no-fault auto coverage. (A-5 n 9). Thus, if certain medical expenses were not covered at all by no-fault auto insurance (as is the case in some states), Respondent Plan *would* cover them.

Understanding the distinction between *no* coverage (which would be the case if a Plan excluded coverage for injuries sustained in an auto accident) and coverage whose level of priority depends upon

(*concluded on page 3*)

(3) Ms. Guetzka's reply would be that Petitioner would not pay because its COB clause makes Respondent primary.

Obviously, Ms. Guetzka's rights against Respondent could not be determined without a ruling on the effect of Respondent's COB provision in the face of Petitioner's COB provision. That determination could *not* be made under state law, because state law is preempted by the ERISA. Therefore, federal law would govern.

The only remaining question would be the rule of decision to be applied. The terms of the ERISA do not provide a rule of decision. Therefore, it would be *necessary* to resort to federal common law. And that takes us to the question presented in the instant case: What is the federal common law rule of decision for the effect to be given unambiguous and conflicting COB clauses?

In the instant case, the only difference from the hypothetical is that Petitioner did not deny Ms. Guetzka's claim, but instead paid all her medical expenses and then proceeded against Respondent as her subrogee. (A-5).[2] Petitioner's action against Respondent is to recover benefits under the Plan to the same extent that Ms. Guetzka would be entitled to recover. Petitioner's arguments are the same as those that Ms. Guetzka would have made. The dispositive question — the fed-

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(*continued from page 2*)

the existence of other applicable coverage (which is the case with COB clauses) is important in analyzing Respondent's argument that Petitioner is seeking a rule which would "mandate benefits" (Pentwater's Brief, p. 13) (discussed, pp. 4-5). The distinction is mentioned at this point only to confirm the accuracy of the text characterization of the dispute.

2 Respondent Pentwater does *not* claim that the ERISA precludes Petitioner from being subrogated to Ms. Guetzka's rights under the Plan. (Compare Brief in Opposition on Behalf of Frederick & Herrud, Inc., pp. 7-10).

eral common law rule of decision — is the same it would have been if Ms. Guetzka had litigated this action instead of her subrogee doing so.

Given the context provided by the foregoing, the legal and conceptual errors in Respondent's argument can be quickly and easily exposed.

First, Petitioner is not asserting greater rights against Respondent than Ms. Guetzka would have (Pentwater's Brief, pp. 9-10). Petitioner, as Ms. Guetzka's subrogee, is seeking no more than "to recover benefits due to" Ms. Guetzka.

Second, Petitioner is not seeking a "new remedy" (Pentwater's Brief, pp. 10-13). Petitioner, as Ms. Guetzka's subrogee, is seeking a dispositive federal rule of decision applicable to Ms. Guetzka's § 502(a)(1)(B) claim for benefits due under the Plan.

Accurately perceived in the conceptual context provided by the foregoing, Respondent's claim that the Michigan Supreme Court fully understood that a subrogee "was bound by the terms of the Respondent Plan" (Pentwater's Brief, p. 10) is nothing more than a conclusory statement of the federal common law rule that Respondent would like this Court to promulgate. It is not, as Respondent suggests, even relevant to the question whether Petitioner is seeking a "new remedy".

B. Promulgating A Federal Common Law Rule Applicable To Conflicting COB Clauses Would Not Mandate That Benefits Be Paid By An ERISA Plan That Does Not Provide Coverage For Injuries Sustained In Automobile Accidents.

Respondent seems to be making two arguments here.

The first is that Petitioner is seeking a rule that would mandate an ERISA Plan to pay automobile accident-

related medical expenses even though the plan "did not cover automobile accidents". (Pentwater's Brief, p. 13). In so arguing, Respondent confuses policies which *exclude* coverage for auto accidents with those which provide coverage which is qualified by the existence of other coverage. (See p. 2 n.1, *supra*).

If coverage is *excluded* by an ERISA plan, by hypothesis there can be no conflict with a COB clause in an applicable insurance policy, because COB clauses are only activated by the *existence* of other coverage. *E.g.*, *Liberty Mutual Ins. Group* v. *Iron Workers Health Fund*, 879 F.2d 1384 (6th Cir. 1989); *Allstate Ins. Co.* v. *Detroit Millmen's Health & Welfare Fund*, 729 F. Supp. 1142 (E.D. Mich. 1990); *Transamerica Ins. Co.* v. *Peerless Industries (Masco)*, 698 F. Supp. 1350 (W.D. Mich. 1988). However, Respondent's Plan does not exclude coverage, but merely makes its level of priority (primary or excess) contingent on the existence of other coverage. Therefore, the question presented to this Court does not even implicate Plans which, unlike Respondent, exclude coverage for auto related injuries.

The second argument seems to be an objection to courts (the only entities which apply federal common law) determining ("mandating") whether a Plan provides coverage. The short answer is that § 502(e)(1) of the ERISA plainly vests both state and federal courts with subject matter jurisdiction to resolve disputes as to the coverage afforded by the terms of an ERISA plan in actions which, like the instant one, are brought pursuant to § 502(a)(1)(B).

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C. The Validity Of The Seventh Circuit's Decision In *Winstead* Was Not Affected By This Court's Decisions In *FMC Corp.* Or *Mertens.*

Respondent asserts, without analysis or explanation, that the Michigan Supreme Court's decision in the instant case does not conflict with the Seventh Circuit's decision in *Winstead* v. *Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. den.* 488 U.S. 1030 (1989), because *Winstead* is no longer viable. None of Respondent's conclusory averments advanced in support of that proposition are accurate.

First, contrary to Respondent's assertion, *Winstead* did *not* apply state law to resolve the issue before it. *Winstead* applied federal common law. 855 F.2d at 433-34 and n. 2. Therefore, as the Sixth Circuit noted in *ACIA* v. *Health & Welfare Plans, Inc.*, 961 F.2d 588, 595 n. 14 (6th Cir. 1992), *Winstead* is not inconsistent with this Court's decision in *FMC Corp.* v. *Holliday*, 498 U.S. 52 (1990).

Second, *Winstead* is not inconsistent with this Court's decision in *Mertens* v. *Hewitt Associates, Inc.*, 508 U.S. ___; 113 S. Ct. 2063 (1993), which held that money damages are not available as "appropriate equitable relief" under § 502(a)(3) of the ERISA. As already noted, the question before this Court is not the existence of a remedy, but rather the federal common law rule of decision applicable in an action seeking to enforce an already extant remedy under § 502(a)(1)(B).

Finally, Respondent argues that *Winstead* is irrelevant because Petitioner's status as Ms. Guetzka's subrogee eliminates the conflict between the COB clauses, because (?) the rights of a subrogee must be determined solely by reference to the terms of the ERISA Plan. The erroneous premise for this argument has already been exposed *supra* at pp. 2-4.

D. State Courts Have Subject Matter Jurisdiction To Decide Actions To Recover Benefits Due A Beneficiary Under The Terms Of An ERISA Plan.

Here, again, Respondent premises an argument on the rule of decision it wants this Court to promulgate, i.e., that the terms of an ERISA plan are to be given full effect even where a COB clause in that Plan conflicts with a COB clause in another applicable insurance policy. However, whether that rule of decision is correct is precisely the question presented to this Court in the instant case. There are other conceptual flaws in Respondent's argument, but assuming as a premise the answer to the question presented is in itself fatal.

Respectfully submitted,

By: DAVID J. LANCTOT
HANLON, BECKER,
LANCTOT, McCUTCHEON,
SCHOOLMASTER & TAYLOR
2000 First Federal Building
Detroit, Michigan 48226
(313) 237-5656
Co-Counsel for Petitioner

By: /s/ JAMES G. GROSS
Counsel of Record
GROSS & NEMETH
444 Penobscot Building
Detroit, Michigan 48226
(313) 963-8200
Co-Counsel for Petitioner

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No. 93-1180

In The

Supreme Court of the United States

October Term, 1993

AUTO CLUB INSURANCE ASSOCIATION,
Petitioner,

v.

PENTWATER WIRE PRODUCTS, INC.,
and
FREDERICK & HERRUD, INC.,
Respondents.

On Petition for a Writ of Certiorari
to the Michigan Supreme Court

SUPPLEMENTAL BRIEF
IN SUPPORT OF PETITION FOR CERTIORARI

DAVID J. LANCTOT
HANLON, BECKER, LANCTOT, McCUTCHEON, SCHOOLMASTER & TAYLOR
2000 First Federal Building
Detroit, Michigan 48226
(313) 237-5656
Co-Counsel for Petitioner

JAMES GEORGE GROSS
Counsel of Record
GROSS & NEMETH
444 Penobscot Building
Detroit, Michigan 48226
(313) 963-8200
Co-Counsel for Petitioner

Interstate Brief & Record Company, *a division of* North American Graphics, Inc.
1629 West Lafayette Boulevard, Detroit, MI 48216 (313) 962-6230

GPP

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No. 93-1180

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AUTO CLUB INSURANCE ASSOCIATION,
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v.

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and
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On Petition for a Writ of Certiorari
to the Michigan Supreme Court

SUPPLEMENTAL BRIEF
IN SUPPORT OF PETITION FOR CERTIORARI

In its Brief in Opposition to Petitioner's Petition for Writ of Certiorari, Respondent Frederick & Herrud raises three basic arguments. Petitioner will respond to them under headings stating its position.

I.

AN INSURER WHO PAYS A DISPUTED CLAIM AND THEREBY BECOMES AN EQUITABLE SUBROGEE OF A PARTICIPANT OR BENEFICIARY OR AN ERISA HEALTH PLAN HAS STANDING TO PURSUE ITS SUBROGOR'S STATUTORY REMEDY AGAINST THE ERISA PLAN. (Frederick & Herrud Issues I.-II.)

At the outset, Petitioner points out that contrary to Respondent Frederick & Herrud's assertion, equitable

subrogation is *not* an equitable *remedy*, but a standing doctrine. A "remedy" denotes what type of relief may be obtained. *See, e.g., Mertens* v. *Hewitt Associates, Inc.*, 508 U.S. ___; 113 S. Ct. 2063 (1993). "Standing" defines who may pursue a remedy: in the instant case, those persons who may bring a civil action under the ERISA. *E.g., Hermann Hospital* v. *Meba Medical & Benefits Plan*, 845 F.2d 1286, 1288 (5th Cir. 1988). Consequently, cases such as *Mertens*, which define the nature of the relief available under the ERISA, are not relevant to this analysis.

As Frederick & Herrud concedes, federal courts do recognize that persons not enumerated in the ERISA may, in certain circumstances, have standing to bring an action against an ERISA health plan. *Hermann Hospital, supra*; *Misic* v. *Building Service Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986). The basis for that rule is twofold.

First, the ERISA does not prohibit the assignment of rights under an ERISA health plan. Second, affording standing to persons who assume the obligation of providing health care to a beneficiary or participant furthers the Act's purpose of protecting beneficiaries from the possibility of not receiving needed medical care as well as from the expenses incidental to litigation against a plan. *Hermann Hospital, supra* at 1290; *Misic, supra* at 1377. Doing so also comports with "the principle of subrogation generally applied in the law." *Hermann Hospital, supra* at 1290.

Contrary to Respondent's assertion, such standing is *not* limited to assignees of participants (who, arguably, could be considered beneficiaries). Both *Misic* and *Hermann Hospital* involved assignees from *beneficiaries*.

Nor, as Respondent suggests, is such standing limited to assignees. Although the Third Circuit has held that

subrogors do not have standing, *Allstate Insurance Co.* v. *The Sixty-Five Security Plan*, 879 F.2d 90 (3rd Cir. 1989), that Circuit — unlike the Fifth (*Hermann Hospital, supra*), Seventh (*Kennedy* v. *Connecticut General Life Insurance Co.*, 924 F.2d 698 [7th Cir. 1991]), and Ninth (*Misic, supra*) — does not recognize even assignees as having standing.

As Respondent points out, no federal circuit has squarely held that a subrogor such as Petitioner has standing to pursue a § 502(a)(1)(B) claim. However, there is direct federal district court authority for such standing, *Allstate Insurance Co.* v. *Operating Engineers Local 324 Health Care Plan*, 742 F. Supp. 952 (E.D. Mich. 1990), and the Sixth Circuit has implicitly recognized it, *Lincoln Mutual Casualty Co.* v. *Lectron Products, Inc., Employee Health Benefit Plan*, 970 F.2d 206 (6th Cir. 1992); *A.C.I.A.* v. *Health & Welfare Plans, Inc.*, 961 F.2d 588 (6th Cir. 1992); *Liberty Mutual Insurance Group* v. *Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989), as has the Seventh Circuit, *Winstead* v. *Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. den.* 488 U.S. 1030 (1989).

The reasoning and rationale of the assignment cases, which Respondent does *not* challenge, are equally applicable to equitable subrogation cases. There is no question but that there is ample federal authority to support Petitioner's standing in the instant case. Moreover, if this Court sees a need to review the rules governing derivative standing under the ERISA, the instant case provides an ideal vehicle for doing so. In that regard, Respondent's argument on this issue hardly provides a basis for *denying* the Petition for Certiorari.

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II.

THERE IS NO UNIFORM FEDERAL COMMON LAW RULE OF DECISION GOVERNING CONFLICTING COB CLAUSES IN ERISA CASES. (Frederick & Herrud Issue III.)

Obviously, the decision of the Michigan Supreme Court directly conflicts with the Seventh Circuit's decision in *Winstead, supra*. Respondent correctly points out that in the context of disputes between ERISA plans, the courts are likewise in disarray. However, Respondent is silent as to how the absence of a uniform federal common law rule serves the purposes of the ERISA. It plainly does not. This Court should take the opportunity to promulgate one.

III.

THE RULE OF DECISION ADVOCATED BY PETITIONER WOULD PROVIDE CERTAINTY AND NATIONAL UNIFORMITY IN ERISA CASES INVOLVING CONFLICTING COB CLAUSES. (Frederick & Herrud Issue IV.)

Strictly speaking, the proper context in which to argue the merits of the rules of decision advocated by the respective parties is in the briefs on the merits. However, because Respondent Frederick & Herrud has made a separate issue of it, a brief response is in order.

The self-evident federal policy to be served by the rule of decision proposed by Petitioner is certainty and national uniformity, both of which further the Congressional intent to minimize the administrative costs of ERISA plans. A rule which would eliminate an entire category of litigation (and litigation-related expenses) would certainly serve that purpose.

The federal policy argument advanced by Respondent Frederick & Herrud is that the rule of decision advo-

cated by Petitioner would increase the cost of ERISA plans, and, therefore, tend to discourage employers from providing benefit plans for their employees. That argument falls one analytical step short of communicating the actual impact the rule promulgated by the Michigan Supreme Court.

Specifically, Respondent neglects to point out that the ultimate cost of *either* rule of decision will be borne by the employees. If a full setoff were available to Petitioner, costs would indeed be shifted to employees through an increase in the costs of ERISA plans. However, if *no* setoff is allowed, the cost will be shifted to the employees in the form of higher automobile insurance premiums.

That is so because coordinated no-fault coverage is (obviously) not available to persons who have nothing with which to coordinate their no-fault insurance. Consequently, employees whose sole health coverage is an ERISA plan would be ineligible for coordinated no-fault coverage. As a result, their no-fault premiums could increase as much as 40%.[1]

The pro rata rule of decision advocated by Petitioner represents a middle ground between the two extremes of cost-shifting, and thereby minimizes to the full degree possible the dislocation to both the no-fault system and the ERISA health plan system. And it does

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1 This Court can confirm that figure by reference to two documents which Petitioner has lodged with the Clerk of this Court. The documents were submitted with briefs filed in the Michigan Supreme Court in *Tousignant* v. *Allstate Insurance Co.* (Michigan Supreme Court No. 93773) and *Owens* v. *A.C.I.A.* (Michigan Supreme Court No. 94544), and are in the records of that Court. This Court therefore may take judicial notice of them. *E.g.*, *United States* v. *Author Services, Inc.*, 804 F.2d 1520 (9th Cir. 1986); *Granader* v. *Public Bank*, 417 F.2d 75 (6th Cir. 1969), *cert. den.* 397 U.S. 1065 (1970).

so while furthering the larger federal policy of rationalizing the ERISA system by providing an easily applied and nationally uniform rule of decision governing conflicting COB clauses.

Respectfully submitted,

By: DAVID J. LANCTOT
HANLON, BECKER,
LANCTOT, McCUTCHEON,
SCHOOLMASTER & TAYLOR
2000 First Federal Building
Detroit, Michigan 48226
(313) 237-5656
Co-Counsel for Petitioner

By: /s/ JAMES G. GROSS
Counsel of Record
GROSS & NEMETH
444 Penobscot Building
Detroit, Michigan 48226
(313) 963-8200
Co-Counsel for Petitioner

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